



Royal Australasian College of Surgeons

Progress Report 2019

Australian Medical Council

ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS



ACFID
MEMBER

Royal Australasian College of Surgeons

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Verify report reviewed

The information presented to the AMC is complete, and it represents an accurate response to the relevant requirements.

Verified by: Mr John Biviano, Chief Executive Officer



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List of acronyms

AIDA	Australian Indigenous Doctors' Association
AMC	Australian Medical Council
AOA	Australian Orthopaedic Association
AOA FTC	Australian Orthopaedic Association Federal Training Committee
AOA 21	Orthopaedic Surgery training program
AORA	Australian Orthopaedic Registrars Association
ASC	Annual Scientific Congress
ASOHNS	Australian Society of Otolaryngology Head and Neck Surgery
ASPS	Australian Society of Plastic Surgeons
ASSET	Australian and New Zealand Surgical Skills Education and Training
Au	Australia
BSET	Board of Surgical Education and Training
CBME	Competency-based medical education
CCrISP®	Care of the Critically Ill Surgical Patient
CE	Clinical Examination
CEO	Chief Executive Officer
CLEAR	Critical Literature Evaluation and Research
CPD	Continuing Professional Development
CV	Curriculum vitae
DBSH	Discrimination bullying and sexual harassment
DIP	Diversity and Inclusion Plan
DoH	Department of Health
DOPS	Direct observation of procedural skills
EB	Education Board
EGM	Executive General Manager
EMST	Early Management of Severe Trauma
FEx	Fellowship Examination
FSSE	Foundation Skills for Surgical Educators (course)
GS	General Surgery
GSET	General Surgery SET
GSSE	Generic Surgical Science Examination
IMG	International medical graduate
MCNZ	Medical Council of New Zealand
MiniCEX	Mini clinical evaluation exercise
MSF	Multi-source feedback
MTS	Medical Training Survey
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
NZOA	New Zealand Orthopaedic Association
NZOHNS	New Zealand Society of Otolaryngology Head and Neck Surgery
OHNS	Otolaryngology Head and Neck Surgery
OWR	Operating with respect (course)
P&RS	Plastic and Reconstructive Surgery
PD	Professional development
PFET	Post-fellowship education training
PPI	Patient and Public Involvement
PRSSP	Plastic and Reconstructive Surgical Science and Principles (Examination)
QLD	Queensland

RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainee Association
RAP	Reconciliation Action Plan
RRA	Reconsideration Review and Appeals
SA	South Australia
SET	Surgical Education and Training
SJT	Situational Judgement Test
SME	Subject matter expert
STB	Specialty Training Board
STP	Specialist Training Program
TAS	Tasmania
TIPS	Training in Professional Skills
VIC	Victoria
WBA	Workplace-based assessment
WA	Western Australia

Standard 1: The context of training and education

Areas covered by this standard: governance of the college; program management; reconsideration, review and appeals processes; educational expertise and exchange; educational resources; interaction with the health sector; continuous renewal.

Summary of significant developments

The Royal Australasian College of Surgeons (RACS) has continued to make significant progress in our transformation towards being an increasingly responsive, modern, and patient-centred organisation.

Strategy

RACS has a new *Strategic Plan 2019 – 2021 and Operations Plan 2019* (Appendix 1) which is underpinned by the three pillars of 'Standards and professionalism', 'Enduring value', and 'Membership'.

During 2019, RACS aims to consolidate this new structure to maximise opportunities for our members. A united 'One College' approach with our surgical specialty societies will be crucial to achieve and embed this cultural change. Key priorities include delivering our core business of surgical education and training, building the confidence of trainees in the training programs, providing better value for members, and improving the efficiency of the organisation and streamlining our governance structure. A 'roadshow' of meetings involving RACS' President, the Chief Executive officer (CEO) and the Executive General Manager (EGM) Education and all the specialty societies and training boards/committees was conducted during March and April 2019 to consolidate and strengthen relationships and build collaboration and consensus for quality improvement.

Organisational Changes

Mr John Biviano was appointed to the role of CEO in April 2019, following the departure of Ms Mary Harney in March 2019. Other changes have been made to the organisational structure, with the underlying rationale of stabilising RACS while moving forward with enhanced capability. The Deputy CEO role is now held by the Chief Operating Officer, Ms Emily Wooden, and a new role, EGM People and Culture, has been created, with the appointment of Ms Sophie Lukeis (previously Manager Human Resources). This new role, reporting to the CEO, recognises the importance of our people to the organisation and the importance of workplace culture within RACS; it also links directly to the Building Respect initiative, which impacts on our Fellows, trainees, and international medical graduates (IMGs). The previous role of EGM Fellowship (responsible for standards, continuing professional development, fellowship services, state/territory and New Zealand offices) has now become EGM Fellowship Engagement, reflecting the need to further 'engage' with the membership. This role is currently under recruitment.

Within the Education portfolio, the EGM Education, Professor Julian Archer, was appointed in January 2019. Under Professor Archer's leadership, three new education management roles have been created. The new Head of Training Services, Ms Veronica Vele, will bring together all those working within RACS in support of our training programs, their governance and support mechanisms. The new Head of Education Services, Ms Phillipa Davies, will oversee RACS' professional development program, skills courses, examinations and IMG assessment. The new Head of Research and Innovation, Dr Tamsin Garrod, will oversee evaluation, quality assurance and innovation within the educational portfolio, in partnership with specialty societies, research and industry.

Within the CEO's office, a new role, Head of Planning and Development, has been created, with the appointment of Ms Rebecca Conning, who will lead RACS business planning co-ordination, governance review and development of a new overarching policy framework. This will have a direct, positive impact on the re-alignment and strengthening of collaborative partnerships with the specialty societies, ensuring quality improvements in all the surgical education and training programs.

Infrastructure

RACS is embarking on a significant program of transformation. While this has been initially focused on the development of an overarching information technology infrastructure project (known as 'Project Sonic'), the approach is now being conceptualised as a wider transformational change program. This change will facilitate the One College initiative, bringing together enhanced RACS data systems, educational initiatives including our training programs as well as events, global health and the membership experience. This transformational change is expected to take place over the next 3-5 years.

Recommendations for improvement

AA	Broaden the definition of conflict of interest to include reflection on an individual's demography, committee roles, public positions or research interests that may bias decision making in areas such as selection or specialist international medical graduate assessment
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RACS is currently undertaking a comprehensive review of policy architecture and processes. This review will include an updated conflict of interest policy. Recommendation AA will be considered in this review which is expected to be complete by mid-2020.

In the meantime, the majority of RACS Specialty Training Boards (STBs) do already comply at board level by declaring any conflicts of interest. RACS' existing interviewer training covers conflict of interest and unconscious bias. Further examples include: RACS STB in general surgery Au who require conflict of interest to be declared prior to participating in selection interviews. The Australian Orthopaedic Association Federal Training Committee (AOA FTC) considers mitigating bias by ensuring a balance of genders and involving specialist and non-specialist participation on selection interview panels. AOA FTC interviewer training in development, includes reflection on conflict of interest and bias. The RACS STB in general surgery NZ replaces selection interviewers if there is a perceived conflict of interest. The RACS STB in otolaryngology head and neck surgery (OHNS) NZ selection balances demographics with a mix of specialities and cultural backgrounds and record conflict of interest when interviewing IMGs.

Activity against conditions

Condition 1	Review the relationships between Council, the Education Board, the Board of Surgical Education and Training and the specialty training boards to ensure that the governance structure enables all training programs to meet RACS policies and AMC standards. To be met by: 2019
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RACS continues to evolve governance systems in relation to the overall structure, relationships with our specialty boards and therefore delivery of training programs.

Significant developments include Council approving in June 2019 the formation of a new Governance Committee. This committee will have oversight of a comprehensive governance review of the College. The new Head of Planning and Development will work closely with a new Policy Architect, to be appointed into the Education Portfolio to specifically review Regulations and Policies related to our educational offer including STBs.

Active discussions continue around the utility of a new Education Committee. RACS held workshops with our STBs and Specialty Societies in September 2018 and in February 2019 to discuss the possible merging of the current Education Board (EB) and the Board of Surgical Education and Training (BSET). Deliberations included the formulation of the terms of reference for a new overarching Committee, including governance and communications to ensure any changes are effective. However, the consultation process has revealed that this model is unlikely to meet RACS' requirements. With this new understanding RACS and our STBs are investigating improvements to better define delineation between and functions of the two-committee system.

Part of the socialisation of all these developments, included the RACS leadership team (Past President, President, CEO and Executive General Manager Education) meeting with STBs Board Chairs and Specialty Societies representatives as part of the annual 'roadshow' in April 2019.

Condition 2	RACS must develop and implement a stronger process for ongoing evaluation as to whether each of these programs remain consistent with the education and training policies of the College. To be met by: 2020
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RACS is developing stronger processes for ongoing evaluation of our STBs and their training programs. STBs are committees of RACS, other than currently, the AOA FTC.

All regulations are submitted by RACS STBs to the RACS EB Executive for assessment of compliance with RACS principle-based policies, in each instance that such a policy has been developed. This process provides a level of reassurance to the Board that surgical programs are consistent with College education and training policies.

However, there is a recognition that the governance of our training programs could be stronger. In direct response to this, RACS commissioned an audit with KPMG. The audit has focused on an internal control and risk assessment of compliance with AMC accreditation obligations with specialty societies. The project scope was discussed with the BSET and the EB in June 2019 and a draft report has been circulated internally for feedback.

The outcome of the audit will be part of what informs current negotiations with the specialty societies regarding their partnership agreements with RACS. It is expected that these will be in place by mid-2020.

Condition 3	Develop a common policy that makes it explicit that all specialty training boards must develop and implement defined reconsideration, review and appeals policies which clearly outline the processes for each of the three phases. To be met by: 2018
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RACS considers that this condition has now been met. In 2019, the EB approved a new policy, *Challenging a decision*, to cover all RACS decisions that might be challenged (Appendix 2). This includes all decisions made by our STBs. Processes are currently being developed in support of the new policy. Implementation will be confirmed by Council in October 2019.

RACS will continue to work with our STBs to support reconsiderations of decisions made by STBs. STBs will continue to oversee the process of reconsiderations but with central reporting mechanisms in place. Reviews and appeals against decisions will now be led by a new RACS Reconsideration Review and Appeals (RRA) Officer and support staff.

As part of the annual revision and renegotiation of specialty training regulations, once they adopt the new policy and RRA processes, RACS STBs will be covered by RACS indemnity insurance for any arising liabilities in relation to training program reconsiderations, reviews and appeals. (Also see response to Condition 29).

Condition 4	<p>Provide evidence of effective implementation, monitoring and evaluation of the:</p> <ul style="list-style-type: none"> (i) Reconciliation Action Plan (ii) Building Respect, Improving Patient Safety Action Plan (iii) Diversity and Inclusion Plan. <p>To be met by: 2021</p>
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RACS inaugural Reconciliation Action Plan (RAP) was launched in June 2016, with actions across four priority areas, Relationships, Respect, Opportunities and Tracking Progress and Reporting. The plan outlines 59 deliverables, 54 have been completed with five in progress. Highlights within the priority areas include:

- Commissioning the Aboriginal and Torres Strait Islander Motif has increased the visibility of Aboriginal and Torres Strait Islander health in the College and is prominently displayed during RACS Indigenous health activities.
- RACS has partnered with the Koorie Heritage Trust in Melbourne to deliver cultural competency training for staff. Training has been offered to all Melbourne-based staff with programs investigated in other Australian states.
- Aboriginal and Torres Strait Islander Health and Cultural Competence e-modules have been promoted to Fellows through the Continuing Professional Development (CPD) program. RACS is working with the Australian Indigenous Doctors' Association (AIDA) with respect to their roll-out of a face to face Aboriginal and Torres Strait Islander Health in Clinical Practice training program that would be tailored for the needs of surgeons.
- In partnership with ASOHNS, the College has led a two-year ear health for life campaign in support of reducing the burden of ear disease in Aboriginal and Torres Strait Islander communities. Successes to date include a new \$30 million investment in hearing assessments over four years, Federal Government support for the \$7.9 million program addressing otitis media in the Northern Territory, and the establishment of a Hearing Health Sector Committee led by Minister Wyatt and development of national KPIs as part of the COAG process.
- The Aboriginal and Torres Strait Islander Health Network was launched to connect Fellows interested in supporting Indigenous health initiatives.
- RACS has formalised a list of Aboriginal and Torres Strait Islander suppliers and promoted this to encourage the use of Indigenous suppliers.
- RACS scholarships in support of Aboriginal and Torres Strait Islander medical students and doctors have increased from \$15,000 in 2016 to \$72,500 in 2018, funded by RACS, the Foundation for Surgery and with support from industry.

Development of the next RACS reconciliation action plan is underway in 2019. RACS proposes to develop a draft framework and seek collaboration and support from the nine surgical specialty societies and associations. RACS' next plan will focus on strengthening relationships with Aboriginal and Torres Strait Islander partner organisations and on implementing new strategies to educate the surgical workforce and support Aboriginal and Torres Strait Islander doctors into surgical careers.

In addition to the three plans identified above, RACS has also implemented the *Māori Health Action Plan 2016-2018*. Highlights in respect of this plan include:

- Māori health inequities are being addressed in a number of ways, such as raising awareness through education sessions for Fellows, trainees and IMGs, and articles in RACS publications.
- A Māori name for RACS, *Te Whare Piki Ora o Māhutonga*, has been adopted and a Māori motif has been developed and is prominently displayed on letterhead, presentation templates and signage. These initiatives are to ensure *Te Ao Māori* is a visible part of the RACS image.

- Cultural competence e-modules and implicit bias tests have been promoted to Fellows, trainees and IMGs.
- RACS staff have participated in training on the Treaty of Waitangi and its implications for health care.
- RACS scholarships are provided to support Māori medical students, prevocational doctors and SET trainees.
- Members of the Māori Health Advisory Group and RACS staff are collaborating with Te ORA and other health agencies to educate personnel and inform practices to reduce health inequities.
- There is an identified representative of the Māori Health Advisory Group on the New Zealand National Board. The intention is to assist the Board to consider potential impact of its decisions on Māori.
- The Māori Health Advisory Group has met with RACS STB representatives and discussed recognition of skills in *tikanga* (knowledge of Māori cultural practices) in selection to SET and inclusion of cultural awareness and safety in curricula. Several RACS specialties have included this in selection interview scenarios (OHNS for New Zealand, orthopaedic surgery NZ; and general surgery NZ) and two (OHNS and orthopaedic surgery NZ) ensure that there is Māori representation on selection panels. Others are looking to follow suit.
- A Māori Health Project Officer has been recruited to implement and progress RACS' plans.

The next iteration of the *Māori Health Action Plan* is in development, with planning underway for a consultation hui with Fellows and trainees, external stakeholders, Māori community and other colleges in the second half of 2019.

RACS has developed a comprehensive evaluation framework, to monitor the reach, progress and outcomes of the Building respect, improving patient safety initiative. Evaluation points are at the three-, five- and ten-year marks. Phase 1 of the Building respect, improving patient safety evaluation has now been implemented and the findings can be found in the *Building Respect Improving Patient Safety Action Plan Phase 1 Evaluation Final Report* (Appendix 3). The Diversity and Inclusion Plan (DIP) is a deliverable of the Building respect, improving patient safety initiative. The DIP aims to increase diversity, including ethnic and gender diversity. Outcomes of the evaluation plus ongoing triangulated findings will inform Building respect, improving patient safety (and DIP) program improvement and evolution, in addition to providing a measure of the extent to which the program goals have been achieved.

Our specialties have demonstrated strong support for the plans, resulting in uptake of the Operating with respect (OWR) online module, and changes to selection criteria to promote diversity, and inclusion of cultural awareness modules in some curricula. The AOA has introduced a *Diversity Strategic Plan 2018–2023*.

Statistics and annual updates

Reconsideration, reviews and appeals

The number of reconsiderations, reviews, and appeals that have been heard in the past year are presented in Table 1, Table 2 and Table 3 respectively.

The EB has approved a new policy, *Challenging a Decision* (Appendix 2). Processes are currently being developed in support of the new policy. Also see response to Condition 3.

Table 1 Requests for reconsideration

Requests for Reconsideration				
Decisions challenged relate to:	Number of requests	Outcome		
		Decision Confirmed	Decision Modified	Pending
Selection process	9	7	2	0
Training Program	14	7	5	2
Dismissal	4	4	0	0
Misconduct	1	1	0	0
Examinations	4	4	0	0
IMG Assessments	17	16	1	0

Table 2 Requests for review

Requests for Review				
Review of challenged decisions reconsidered relate to:	Number of requests	Outcome		
		Decision Confirmed	New Decision	Pending
Training Program	5	3	0	2
Dismissal	4	3	0	1
IMG Assessments	1	0	1	0

Table 3 Appeal hearings July 1, 2018 – June 30, 2019

Requests for Appeal				
Challenged decisions that progressed to appeal relate to:	Number of appeals	Outcome		
		Appeal Dismissed	Appeal Upheld	Pending
Dismissal	3	1		2

Governance Policies/Procedures

Changes to the following documents since the last progress report.

Changes are described in Table 4 and the updated documentation are attached to this progress report. See Appendix 4 and Appendix 5.

Table 4 Royal Australasian College of Surgeons governance (policies and procedures)

Policies/Procedure	Description of Changes		
College Governance Chart (Appendix 4)	Organisational committee restructure review in progress		
RACS Executive Leadership Team (Appendix 5)	Title	Name	Appointed
	CEO	Mr John Biviano	Apr 2019
	Deputy CEO and COO	Ms Emily Wooden	Apr 2019
	EGM, Education	Prof Julian Archer	Jan 2019
	EGM, Partnerships	Ms Susan Wardle	Aug 2018
	EGM, People and Culture	Ms Sophie Lukeis	Jun 2019
	EGM, Fellowship and Engagement	To be appointed	

Standard 2: The outcomes of specialist training and education

Areas covered by this standard: educational purpose of the educational provider; and program and graduate outcomes

Summary of significant developments

A high-level business plan was developed in 2017 – the *Education Program of Work 2018-2020* – to provide focus for the educational outcomes to be achieved by 2020. This plan is currently under review. With new key appointments in 2018-19, there has been an opportunity to revisit the schedule and redesign our approach to fulfilling the requirements for ongoing accreditation by the AMC and the Medical Council of New Zealand (MCNZ). A fully costed model will be presented to the RACS Council in October 2019.

The focus of the plan will be to enhance and implement program improvements across the continuum of training and education including a particular focus on the monitoring and evaluative components. This will provide better oversight of RACS training programs including, in time, program and graduate outcomes.

Recommendations for improvement

BB	Benchmark the graduate outcomes of each of the surgical training programs internationally.
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RACS and many of our specialty training boards (STBs) have been undertaking a range of curricula reviews in the last few years. Curricula reviews have each involved benchmarking graduate outcomes through international review of other surgical programs. Most recently, the RACS STB in urology is undertaking a curriculum redevelopment, benchmarking against international curricula and standards. Several RACS STBs and committees, including general surgery Au and NZ, neurosurgery, OHNS, orthopaedic surgery, and P&RS, have recently completed or are in the process of completing curriculum reviews. In each case benchmarking graduate outcomes through international review of other surgical programs has been completed.

CC	Improve the uniformity of presentation of training program requirements and graduate outcomes for each of the surgical specialties (particularly on the website), taking into account feedback from trainees, supervisors and key stakeholder groups
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The 2019/2020 policy review in conjunction with the service agreements between RACS and each specialty group is anticipated to provide a template approach to guide uniformity for presentation of training program requirements. RACS is leading a major program of change in the coming years which will include the development of better systems to oversee training programs. This approach will allow for better uniformity of presentation of training program requirements and graduate outcomes for each of the surgical specialties as part of this new 'One College' approach.

DD	In conjunction with the specialty training boards, review and report on the reasons for the pervasiveness of post-fellowship training and any potential impact on the appropriateness of the Surgical Education and Training (SET) program.
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RACS continues to host a small number of post-fellowship education training (PFET) programs in subspecialty areas (currently five). These include, for example, partnerships between the RACS STB in P&RS Au, RACS STB in OHNS and the AOA Federal Training Committee (FTC) offering post-fellowship training provided in two subspecialties: hand surgery and craniomaxillofacial surgery. Most post-fellowship 'training' is either sub-

specialist (so not the primary focus of any of the nine specialty training programs), or represents opportunities for widening and advanced experience. These include for example, cardiothoracic surgery new Fellows expecting to complete an overseas fellowship of 12-24 months following completion of FRACS, with the purpose of clinical maturation, broadening skills, and increasing awareness of alternative and innovative practices. RACS STB in general surgery Au encourages fellowship posts, and their impacts on training are reviewed during quinquennial inspections. Hospitals with RACS general surgery Au Fellows are required to have delegation of responsibilities to ensure that trainees obtain the appropriate and required training.

Some areas of experience are hard to attain in some training programs. One example is the RACS STB in urology, where the adoption of technology (and procedures) not readily available in the public health system has been a significant driver toward post-fellowship training. It is apparent that competence cannot be achieved in all aspects of urology during the training program, and urologists completing training will thus have constraints placed upon their scope of practice. The use of technology and training surgeons for future practice is currently under review at RACS – including discussions around the role of and access to training in robotics. The federally funded Specialist Training Program (STP) in Au provides some opportunities for experience in the private sector which may be one way forward. The situation continues to be reviewed by RACS.

Activity against conditions

Condition 5	Define how the College's educational purpose connects to its community responsibilities. To be met by: 2020
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As defined in our *Strategic Plan 2019-2021* (Appendix 1), RACS is patient-centred. A key responsibility and educational objective is to support the training and sustaining of the surgical workforce to address the needs of the Australian and New Zealand peoples.

RACS is achieving this by working to better reflect the communities we serve; by providing surgeons where people live; and by placing people and culture at the heart of what we do. RACS is recognised internationally as a leader in working to improve patient safety through building respect, including our approach to diversity and inclusion (see Condition 4 which speaks to our work in Building respect, improving patient safety and our DIP plan).

Specifically, in education and training, RACS is working to support diversity in the surgical workforce through revision of selection practices. RACS has recently completed a pilot to establish the validity of Situational Judgement Tests (SJTs) for selection to surgical training. SJTs commonly assess traits including leadership skills, communication skills, integrity, and empathy. Importantly, there is evidence that SJTs are less impacted by socio-economic and cultural bias than are other selection tools and therefore support diversity. SJTs will most likely be used as part of the selection tool kit into surgical training from 2020.

The Australian Federal Government's Specialist Training Program (STP) seeks to extend vocational training for specialist registrars into settings outside traditional metropolitan teaching hospitals, including regional, rural, remote and private facilities. The program aims to improve the quality of future specialist workforce by providing registrars with exposure to a broader range of healthcare settings. STP also aims to have a positive influence on future workforce distribution. The RACS STP has now achieved funding of 59 surgical training positions across mainland Australia, and 8.4 specialist surgical positions in Tasmania. RACS has a Rural Surgery Section in the College to advocate for rural surgeons and establish networks to support surgical training and practice in rural and remote settings.

RACS is currently reviewing the framework of our nine RACS competencies and is looking to better establish cultural competence at the heart of educational standards. The poor health outcomes of several groups within our communities, especially those of Māori and Aboriginal and Torres Strait Islanders, are clear reasons for this to be a key issue for RACS to address. Alongside this review, a new professional skills curriculum is being developed and will be launched in 2020. These reviews of competencies and professional skills that underpin

surgical training and practice reflect societal values and will positively influence interactions between RACS and the communities we serve.

RACS is a signatory to the Australian Consensus Framework for Ethical Collaboration in the Healthcare Sector. Through this organisation, RACS regularly collaborates with professional bodies, industry organisations, hospitals and health services associations, regulators, patient and consumer advocacy groups specifically to address ethical issues in the health sector.

Each STB has now appointed an external community representative. These representatives provide input regarding the community's expectations regarding surgical training. Specific initiatives include: 1) AOA's community responsibilities have been clearly defined by the AOA Ethical Framework; 2) ASPS has worked with The Ethics Centre (an independent not-for-profit organisation) to develop an Ethical Framework that reflects the commitment of ASPS members to the wider community; and 3) to reflect the importance of OHNS surgeons' responsibilities to the communities they serve, the OHNS specialty curriculum was developed with consideration to name and present the curriculum topics from the patients' perspective.

Condition 6	Broaden consultation with consumer, community, surgical and non-surgical medical, nursing and allied health stakeholders about the goals and objectives of surgical training, including a broad approach to external representation across the College. To be met by: 2021
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In the past three years, RACS has engaged with community representatives, jurisdictions and external agencies in several activities. This engagement includes appointing community representatives to all RACS STBs and major committees involved in educational governance, as well as to hospital post accreditation teams and IMG interview panels. RACS also liaised with the Human Rights Commission and consumer advocates in developing our Operating with Respect (OWR) eLearning and face-to-face course.

Major projects being undertaken by RACS, such as revising the Code of Conduct and implementation and review of Building respect, improving patient safety include input from non-surgeon stakeholders. RACS has also worked with the Consumer Health Forum on patient information regarding fees. Projects such as these provide models of consultation with non-surgical stakeholder groups that are readily adapted to our educational activities.

RACS is considering establishing a Patient and Public Involvement (PPI) Forum to support our community representatives and to stimulate further development in this domain. The forum would consider and advise RACS on scope of membership and activities. (Also see response to Condition 21).

RACS recognises the need to further our engagement with the broader community in educational development such as through initiatives such as a possible PPI Forum. Accordingly, RACS will seek input from community members as it develops a professional skills curriculum, introduces selection based on behavioural attributes, and explores feedback mechanisms from surgical teams.

Condition 7	Clearly and uniformly articulate program and graduate outcomes (for all specialties) which are publicly available reflect community needs and which map to the nine RACS competencies. To be met by: 2021
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RACS commenced a review of the *Surgical Competence and Performance Guide* in early 2019. This publication currently describes the core nine RACS competencies and their related behavioural markers.

Revising the guide entails appraisal of the nine RACS competencies, which has implications for many facets of training, including articulation of program and graduate outcomes. Following publication of the revised *Surgical Competence and Performance Guide*, RACS will work with our STBs to ensure that program and

graduate outcomes are explicit, reflect the new guide and the RACS competencies, represent community needs and are publicly available on the RACS website. Importantly, through this review RACS will work with our STBs to ensure better alignment between program and graduate outcomes across all our specialties.

Greater uniformity across RACS programs will be achieved over time by the stronger partnerships that are developing between RACS and the surgical specialty societies and associations.

Statistics and annual updates

Nil required.

Standard 3: The specialist medical training and education framework

Areas covered by this standard: curriculum framework; curriculum content; continuum of training, education and practice, and curriculum structure.

Summary of significant developments

All specialty training boards (STBs) report their support for competency-based curricula. RACS STBs are on a journey towards implementing competency-based curricula.

Recommendations for improvement

EE	Develop explicit criteria to consider whether training periods of less than the standard six months can be approved, and ensure that prior learning, time and competencies acquired in non-accredited training are fairly evaluated as to whether they may count towards training.
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Most RACS STBs now have mechanisms in place to approve training periods of less than six months under particular circumstances. This includes the RACS STBs in general surgery Au, P&RS Au, OHNS, and urology. The AOA FTC also approves 3-month training periods as standard for orthopaedic surgery trainees. Most RACS specialties also have policies in place to recognise prior learning.

FF	Make available to all trainees the learning modules under the Building Respect, Improving Patient Safety (BRIPS) program, once most or all College Fellows are trained
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The initial drivers in the RACS Building respect, improving patient safety campaign were to target existing Fellows to bring about early culture change. Near full compliance has now been achieved with the Foundation Skills for Surgical Educators (FSSE) and Operating with Respect (OWR) courses. RACS is now moving to roll out the initiative more widely to trainees and surgical teams. The OWR is being developed for trainees currently and is at the pilot stage. OWR is also being offered increasingly for other members of the surgical team. RACS STB in general surgery Au, P&RS Au, and urology all now encourage their trainees to complete Building respect, improving patient safety modules, including FSSE. Four AOA 21 workshops have been hosted to date (which have been assessed as comparable to the FSSE) and are a requirement of the AOA 21 training program. The RACS Training in Professional Skills (TIPS) course has also now been mandated by a number of RACS STBs.

Activity against conditions

Condition 8	Enhance and align the non-technical competencies across all surgical specialties, including a consideration of the broader patient context. To be met by: 2021
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In order to better align the approach to non-technical competencies across all surgical specialties, RACS is currently developing a generic professional skills curriculum. Work completed to date includes a literature review to define potential curriculum content, training and assessment models and curriculum implementation models, including a review of new surgical specialty curricula.

Sharing of curricula content will enhance consistency and alignments between specialty curricula and the professional skills curriculum. Best practice examples are already being identified. These include: the RACS STB in cardiothoracic surgery, who are incorporating non-technical aspects into training courses; the RACS STBs in general surgery Au and general surgery NZ who will include entrustable professional activities (EPAs)

for non-technical competencies and will mandate TIPS from 2021; the AOA FTC who has mandated TIPS for all trainees; the RACS STB in OHNS and P&RS Au and P&RS NZ who have integrated training and assessment of non-technical skills in the new curricula. The RACS STB in P&RS NZ has also mandated TIPS, the RACS STB in urology has commenced training in non-technical competencies; and the RACS STB in vascular surgery has introduced a mandatory leadership course.

Fellows from across the RACS specialties are coming together to actively participate in a working group to identify and develop the professional skills curriculum content. Input is also sought from community representatives, the Indigenous Health Committee and the TIPS Committee. The working group is scheduled to convene in the second half of 2019, predicated on the outcomes of a review of the nine RACS competencies and the *Surgical Competence and Performance Guide*, as discussed in Condition 7.

Condition 9	<p>As it applies to the specialty training program, expand the curricula to ensure trainees contribute to the effectiveness and efficiency of the healthcare system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of settings within the Australian and/or New Zealand health systems.</p> <p>To be met by: 2021</p>
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RACS recognises the importance of curricula to ensure trainees contribute to the effectiveness and efficiency of the healthcare system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of settings within the Australian and/or New Zealand health systems. The generic professional skills curriculum, under development, will include competence in the delivery of safe, ethical high-quality and cost-effective health care across a range of settings within the Australian and/or New Zealand health systems.

RACS STBs in general surgery Au, general surgery NZ, OHNS, urology and the AOA FTC has taken steps to cover this content in the current curricula. Several other RACS STBs, including cardiothoracic surgery, general surgery NZ, P&RS Au, and vascular surgery, are currently reviewing their curricula and intend to include content relevant to developing knowledge and understanding of the issues associated with the delivery of safe, high-quality and cost-effective health care across a range of settings in the near future.

Condition 10	<p>Document the management of peri-operative medical conditions and complications in the curricula of all specialty training programs.</p> <p>To be met by: 2021</p>
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RACS STBs in cardiothoracic surgery, general surgery Au, general surgery NZ, neurosurgery, OHNS, and paediatric surgery and the AOA FTC have addressed this issue in current curricula. RACS STBs in general surgery NZ, orthopaedic surgery NZ, P&RS Au and NZ, urology, and Vascular surgery are currently reviewing their curricula and will address this issue in new curricula.

Condition 11	<p>Include the specific health needs of Aboriginal and Torres Strait Islanders and/or Māori, along with cultural competence training, in the curricula of all specialty training programs.</p> <p>To be met by: 2021</p>
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In addition to the Education Advisor, RACS has appointed an Aboriginal and Torres Strait Islander Health and Cultural Safety Project Officer to assist RACS specialties to embed cultural awareness and safety into the

SET program. The Project Officer developed a communications plan in May 2019 and is currently visiting each of the RACS STBs to provide guidance and support. Below is an outline of the plan for 2019.

The project is informed by the 'Closing the Gap' (2019) report and the Department of Health priorities for Aboriginal and Torres Strait Islander training as well as by AMC priorities, particularly those related to the RACS strategic plan (2019 – 2021) and the Reconciliation Action Plan.

The cultural awareness and safety project focuses on how RACS' members (trainees, international medical graduates and Fellows) can work to improve health services for Aboriginal and Torres Strait Islander patients. It identifies improvements to health care services through equity of access to culturally safe health care. Implementation involves eLearning modules, education and exams and assessment areas, a review of identified process to include in specialty boards and documentation.

In September 2018, RACS secured a 2.5-year \$460,000 grant from the Australian Department of Health to support curricula review and gap analysis to develop resources for training in Aboriginal, Torres Strait Islander health and cultural safety.

The Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative has been implemented by 8 of 9 STBs. The first trainee selected as part of the initiative started training in cardiothoracic surgery in 2019. Vascular surgery will introduce a Māori Selection Initiative for selection into training in 2020.

Australian Indigenous Doctors' Association (AIDA) and Te Ora representatives sit on RACS Indigenous Health Committee, and Presidents or delegate regularly attend the RACS Annual Scientific Congress (ASC).

The Māori Health Action Plan: A hui in late 2019 is proposed to discuss progress, current initiatives and future plans. The gathering will include surgical and non-surgical participants, including those from other medical colleges, Māori organisations, and representatives from RACS' STBs. The next Māori Health Action Plan will be drafted after the hui. The Māori Health Advisory Group has met with several of the STBs to discuss curricula development. A proposal is being formulated to obtain funding to extend the cultural awareness and safety project to include Māori.

RACS is working with the AIDA to deliver a face-to-face Aboriginal and Torres Strait Islander Health in Clinical Practice training program, tailored to the needs of surgeons. As part of the Continuing Professional Development (CPD) program Aboriginal and Torres Strait Islander Health and Cultural Competence e-modules have been promoted to Fellows.

RACS STBs in general surgery Au and NZ, OHNS, and P&RS NZ, and the AOA FTC provides educational opportunities in cultural competence. The AOA FTC has developed learning resources on communication with Aboriginal and Torres Strait Islander patients. The RACS OHNS curriculum has a dedicated module on the health needs of Aboriginal and Torres Strait Islander and Māori patients and cultural competency. The RACS P&RS Au Board have included cultural competence as a criterion in their training post accreditation. Other specialties, including cardiothoracic surgery, orthopaedic surgery NZ, paediatric surgery, and urology, are working to incorporate cultural awareness training and training on health needs of Aboriginal and Torres Strait Islanders and/or Māori into their curricula. The RACS STB in vascular surgery is including the specific health needs of Aboriginal and Torres Strait Islander and/or Māori in the current curriculum review process.

Condition 12	In conjunction with the specialty training boards, develop a standard definition across all training programs of 'competency-based training', and how 'time in training' and number of procedures required complement specific observations of satisfactory performance in determining 'competency'. To be met by: 2020
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Most RACS STBs have now developed and implemented competency-based training programs and have gained an appreciation of what this means in practice. However, we are yet to develop a standard definition across all programs. To address this, in the second half of 2019, RACS will work with specialty representatives to develop a standard definition of competency-based training. Alongside this, we will establish the RACS

approach to how we balance competency frameworks with minimum 'time-in-training' approaches. RACS STBs' general consensus is that a minimum time in training is required to ensure sufficient exposure to requisite procedures and the number of specific observations of satisfactory performance in determining 'competence'.

Condition 13	RACS has a policy that is applicable to all specialty training programs to remove the overt and hidden barriers to flexible forms of training. RACS must build on the existing policy and processes, and liaise with hospitals to implement flexible training. To be met by: 2018
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Supporting trainees to train with flexibility, if they desire to do so, is fundamentally important to RACS. However, RACS acknowledges the complexities of balancing the service needs of hospitals, with surgical training that is still informed by logbook records and some time-based activities. Moving to full implementation of competency-based training should remove some of the barriers.

RACS recognises the ongoing importance of flexible training to trainees. The results of the Royal Australasian College of Surgeons Trainee Association (RACSTA) *Rotation One Survey* (2018) indicate that 27.4% (n=329) of respondents would be interested in applying for flexible training. This figure is consistent with previous survey findings.

Importantly, significant progress has been made during 2018 and our STBs who have the capacity to facilitate flexible training are now approving flexible posts and updating training regulations accordingly. In 2019, all RACS STBs and the AOA RTC regulations accommodate flexible training. However, flexible training posts remain the responsibility of hospital boards, as they are dependent on funding and implementation by prospective employers.

A report on the number of current trainees in flexible posts and hospitals that have indicated they can support flexible training positions showed that there are currently 15 filled accredited 'flexible training' posts in eight hospitals across Australia and New Zealand. RACS will continue to monitor uptake of flexible training opportunities. As flexible training becomes 'normalised' among hospitals, our STBs and trainees, it is hoped that momentum will build and these numbers will increase.

RACS is currently undertaking a full review of regulations, policies and procedures. As part of this initiative, the *Trainee Registration and Variation Policy* and the *SET Fee Policy* will be updated to ensure greater clarity around flexible training and associated fees. At present, it is only possible for trainees to pay 50% or 100% of the training fees. This will be changed so fees reflect the proportion of full-time training that trainees undertake.

Statistics and annual updates

Nil required.

Standard 4: Teaching and learning approach and methods

Summary of significant developments

As specialty curricula are revised, new approaches to curricula development, workplace-based assessments, entrustable professional activities (EPAs) and outcome criteria are being explored and adopted.

Recommendations for improvement

GG	Consider options to mitigate the lack of training in some parts of Australia and New Zealand, such as in outpatient settings, endoscopy and aesthetic surgery
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RACS is working to try to mitigate the lack of training in some parts of Australia and New Zealand such as in outpatient settings, endoscopy and aesthetic surgery. Most RACS specialties now ensure trainee access to outpatient clinics via the post accreditation process. The RACS specialty training board (STB) in urology has identified alternative solutions in locations where access to outpatient clinics is insufficient. Processes are in place to ensure adequate training in this domain, including the provision of outpatient exposure in private settings where required.

RACS STB in general surgery NZ acknowledges that endoscopy training in New Zealand is an issue due to the drive to train more gastroenterologists for the National Bowel Screening Program. This has impacted on the numbers of endoscopy procedures available to general surgery trainees. The RACS STB in general surgery Au has introduced a hospital post accreditation standard for all new posts. Hospitals must now provide at least one consultant-supervised outpatient clinic, with new and follow-up patients, per week. RACS STB in general surgery NZ has elected not to increase the trainee burden for endoscopy or colonoscopy numbers in the new GSET program, and it is expected that trainees wishing to sub-specialise in GI/Colorectal surgery will seek the experience themselves, either during training or during a fellowship period.

The RACS STB in P&RS Au now requires hospital posts applying for re-accreditation to articulate the length of time trainees may rotate through a private setting, and to have exposure to curriculum topics including the extent of aesthetic surgery training opportunities. The RACS STB in P&RS Au reports that the proportion of procedures that are used to train surgical registrars on the operative techniques used by plastic surgeons to maximise the 'cosmesis' (aesthetic impact) of a surgical procedure has increased from 46% in 2009 to 77% - 79% in 2018/2019.

The AOA FTC reinstated four training posts that had been dis-accredited due to lack of outpatient exposure, once the site provided private clinic access to trainees.

Activity against conditions

Condition 14	For all specialty training programs, develop curriculum maps to show the alignment of learning activities and compulsory requirements with the outcomes at each stage of training and with the graduate outcomes. This could be undertaken in conjunction with the curricular reviews that are currently planned or underway. To be met by: 2021
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RACS is currently undertaking an IT project review of business systems. This transformational program aims to assess all platforms, processes, policies and resources to ensure they are ready to take RACS into the future. The target state 'blueprint' and 'road map' were presented to Council in late June 2019. As part of the road mapping exercises, a trainee ePortfolio mapped to each stage of surgical training is planned, providing links to educational resources and assessments. RACS STBs in cardiothoracic surgery and paediatric surgery will be involved in the development and planning processes.

RACS STBs in neurosurgery, orthopaedic surgery NZ, OHNS, and P&RS Au have now mapped learning activities to the outcomes at each stage of training. The AOA FTC has also completed this. RACS STBs in general surgery Au and NZ, urology, and vascular surgery are planning to adopt this recommendation as part of their current curriculum reviews.

Statistics and annual updates

Nil required.

Standard 5: Assessment of learning

Areas covered by this standard: assessment approach; assessment methods; performance feedback; assessment quality

Summary of significant developments

Improvements to the conduct of the Fellowship Examination (FEx) continue to be implemented in response to feedback received from Fellows and candidates.

The Clinical Examination (CE) has been reviewed and will be moved out of RACS training programs. From 2022, six specialty training programs will require successful completion of the CE as a prerequisite to selection to training.

Recommendations for improvement

HH	Review the compulsory General Surgical Science Examination requirement in terms of usefulness, preparation time and financial burden for those who are not selected for entry into surgical training. (Standard 5.2.1)
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RACS believes that the Generic Surgical Science Examination (GSSE) is a valuable contributor to the early education of surgical training candidates. It serves as an effective means of ensuring those entering surgical training have achieved a satisfactory standard of surgical science knowledge to build upon at entry into SET. Given the variability of surgical science knowledge addressed in university medical degrees, establishing a benchmark of knowledge for entering SET is vital, as the curriculum anticipates a level of assumed knowledge. The GSSE serves as both motivation for, and assurance of, potential candidates achieving this knowledge.

II	Review whether the Clinical Examination remains an essential assessment task, given that the 2016 Review of Assessment Report notes its poor reliability and trainee feedback questions its validity. (Standard 5.2.1)
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Many RACS specialty training boards (STBs) have now removed the CE as an assessment requirement during SET, however there is a high degree of support from STBs to use the CE in selection to SET. A 2018 RACS study found that the CE (in SET) is a predictor of FEx performance. The predictive validity of the CE will be further analysed once it is fully established in the pre-vocational space as a requirement for selection into training.

JJ	For all surgical specialties, adopt behaviour-related reporting (i.e. descriptive of the key features) rather than simple scoring for all work-based assessments.
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RACS STBs are transiting to behavioural descriptors in work-based assessments and/or entrustable professional activities (EPAs). For example, behavioural descriptors in work-based assessments have been adopted by RACS STB in P&RS Au, and general surgery Au will adopt EPAs from 2021. The AOA Federal Training Committee (AOA FTC) already uses behavioural descriptors in work-based assessments and the RACS STB in urology will be incorporating them into a curriculum review on assessment processes.

KK	Explore the use of multi-source feedback for all surgical training programs at set points throughout training.
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It is likely that RACS will introduce regular multi-source feedback (MSF) for trainees as part of an overarching framework for monitoring and evaluation, which includes all training and educational processes as well as program and graduate outcomes (see Condition 17). To date, RACS STBs in cardiothoracic surgery, general surgery Au, paediatric surgery and urology are using MSF, for trainees in difficulty. Most MSF/360 evaluations are currently only used for trainees in difficulty or for SET1 trainees.

LL	Review whether the term 'essay-type' is appropriately used in all its current contexts. Where essay-type questions are used, consideration should be given as to whether they could be replaced with short-answer type questions.
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The structure and processes in the RACS FEx remain under review and continue to evolve. For example, urology has ceased to use essay-type questions, and now routinely use short-answer questions in the FEx. No specialty uses essay-type questions only; where essays are used, they are combined with other types of questions. General surgery uses both image-based 'spot' questions and short-answer questions; orthopaedic surgery uses a combination of illustrated short-answer questions, 'extended answer' essay type questions and MCQs; vascular surgery use essay-type questions and short-answer questions.

A review of the validity evidence of the Fellowship and other RACS examinations is planned in the coming years.

Activity against conditions

Condition 15	Respond to the 2016 Review of Assessments Report by Cassandra Wannan by noting whether recommendations have already been implemented, require implementation or are rejected, including a rationale for the latter. To be met by: 2018
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The 2016 *Review of Assessments Report* by Cassandra Wannan provided an excellent framework against which to undertake a program of work to revise and improve both workplace-based assessment (WBA) and RACS specialty examinations. RACS continues on a journey in evaluation of our range of assessments.

This condition has now been addressed by the inclusion of Appendix 6 in which we tabulate our responses to each of the Wannan recommendations. In summary, RACS has only rejected one recommendation around the use of entrustability scales for WBA. This is because WBAs are designed to assess the smaller building blocks of competency-based medical education (CBME), while entrustability scales are linked to a different approach, using EPAs.

Significant initiatives include the program of work already undertaken to support high quality feedback by supervisors to trainees following WBAs and as part of the FEx. A RACS-wide review of standard-setting procedures has also been completed and implemented.

A full review of the assessment profile of the College will be undertaken in the coming years under the leadership of, Professor Julian Archer, who is an internationally recognised medical education researcher specialising in assessment and regulation. The assessment profile review will include an evaluation of the validity evidence for the FEx. The introduction of a comprehensive examination question management system, currently in development, will facilitate storage, development and statistical analysis of the performance of examination questions, in all RACS examinations.

Condition 16	Implement appropriate standard setting methods for all specialty-specific examinations (The AMC recognises that at least three specialties are already compliant in this respect). To be met by: 2019
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RACS has addressed this condition in 2019 by reviewing all specialties' standard-setting practices. This has been informed through research into good practice in examination standard-setting, presenting recommendations to RACS surgical specialties that conduct specialty-specific examinations and consulting with RACS specialties regarding approaches to implementing preferred standard-setting methods. Change has been supported by conducting a series of workshops to pilot new standard-setting methods and train subject matter experts (SMEs).

Outcomes of this process are that the RACS Neurosurgery Anatomy Examination, implemented as a selection tool, now uses a formula based on question difficulty to set the pass standard. Two RACS specialties (OHNS and vascular surgery) retained their existing standard-setting method (modified Angoff method), RACS STB in urology assessments have adopted the modified Angoff method, which will be implemented in 2020. The SSE and CE Committee will take responsibility for standard-setting the RACS STB in Plastic and Reconstructive Surgical Science and Principles Examination (PRSSP) from 2020. RACS STBs and committees in cardiothoracic surgery, orthopaedic surgery, paediatric surgery, and urology have undertaken or have scheduled workshops to pilot the modified Angoff method in 2019, anticipating implementation in 2020.

Statistics and annual updates

Summative assessment activity for the Surgical Sciences Examinations, Clinical Examination and Fellowship Examination, including the number and percentage of candidates sitting and passing is presented in Table 5.

Please note that the low number (n=10) of SET trainees attempting the GSSE reflects the shift of this examination from being a requirement during SET to becoming a pre-requisite for selection to SET. Ongoing low pass rates for IMGs attempting the Fellowship Examination are being addressed by providing support to IMGs attempting this exam and by exploration of other methods of assessing IMGs' competence (see standard 10).

Table 5 Examination pass rates 1/1/2018-31/12/2018

Examination Activity	Number of candidates sitting examination	Number of candidates passing examination	% of candidates passing examination
Generic Surgical Science Examination – JDocs and non-SET candidates	981	594	60.55
Generic Surgical Science Examination – SET trainees	10	3	30.00
Specialty-Specific Surgical Sciences Examination	178	140	78.65
Clinical Examination	228	156	68.42
Fellowship Examination – all attempts*	377	248	65.78
Fellowship Examination – annual pass rate#	307	248	80.78
Fellowship Examination – SET trainees	330	227	68.79
Fellowship Examination – IMGs	47	21	44.68

* 'All attempts': reports number of Fellowship Examination attempts; some candidates sit twice during a year.

'Annual pass rate': reports the pass rate for individual candidates (over one or two sittings) attempting the Fellowship Examination.

Standard 6: Monitoring and evaluation

Areas covered by this standard: program monitoring; evaluation; feedback, reporting and action

Summary of significant developments

Phase 1 of the Building respect, improving patient safety (Building respect, improving patient safety) evaluation at three years has now been implemented and the findings are presented in Appendix 3. An overarching evaluation plan will be developed during 2019 in order to provide better oversight by RACS of our training programs.

Recommendations for improvement

MM	Explore with trainees how response rates to surveys on training posts could be improved.
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Several RACS specialty training boards (STBs) find it difficult to obtain truly confidential feedback when the number of trainees is small, and this impacts on response rates. However, initiatives are developing to try to deal with this broadly recognised issue. For example, RACS STB in neurosurgery has addressed this issue by creating a three-year rolling report for training units as a way to provide feedback without breaching trainee confidentiality. The RACS STB in urology and the AOA FTC report excellent response rates to their trainee surveys. Some RACS specialties use the biannual Royal Australasian College of Surgeons Trainee Association (RACSTA) surveys as their primary trainee surveys. The RACSTA survey is under review as part of RACS plans to develop an overarching framework for monitoring and evaluation, which includes all training and educational processes as well as program and graduate outcomes. (Also see response to Condition 17).

NN	Implement the planned New Fellows' Survey to evaluate their preparedness to practise and the annual survey of trainees who leave surgery without completing the program.
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Following the New Fellows survey (2018), in which many respondents indicated low confidence regarding their preparedness for practice, post-fellowship training and transitioning to practice were discussed at the May 2019 Younger Fellows Forum. A formal recommendation from the meeting will be presented to Council in October 2019.

Activity against conditions

Condition 17	Develop an overarching framework for monitoring and evaluation, which includes all training and educational processes, as well as program and graduate outcomes. To be met by: 2019
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RACS is making progress to develop an overarching framework for the monitoring and evaluation of all our training and educational processes. There have been a number of initiatives to achieve an overarching approach. These include:

RACS STBs completed an 'educational journey' audit in which educational resources supporting learning objectives of the surgical training programs have been identified and mapped to the nine RACS competencies.

RACS STB in general surgery Au will undertake an evaluation of trainees' opinions regarding the current program compared to those in the new program. Following the first full year of the AOA 21 Training Program, the AOA FTC is commencing a preliminary review of their monitoring and evaluation framework. The Australian Society of Plastic Surgeons (ASPS) education unit, in support of the RACS P&RS Au training program, has

implemented a practice of continuous improvement, with areas covered including selection, hospital posts, and training events. Activities earmarked by ASPS for improved monitoring and evaluation include a “whole of SET program” evaluation, targeted supervision evaluations, and administrative process reviews (assessments, communications, annual reports). The new urology curriculum incorporates processes for monitoring and evaluating the curriculum content, the delivery processes, the alignment of teaching and assessment processes to the curriculum, and the graduate outcomes.

RACS is trialling a course evaluation ‘dashboard’ to evaluate defined aspects of all professional development (PD) activities. Following the trial implementation, RACS will appraise this evaluation approach to ascertain its potential for broader applicability across other training and educational processes. The framework includes descriptions of the review cycle, feedback cycle, program improvement, and implementation mechanisms.

An example of the Course Evaluation Dashboard for the professional development workshop: ‘Surgeons as leaders in everyday practice’ is presented in Figure 1. This dashboard provides an example of reporting RACS’ performance against a benchmark in identified parameters, allowing targeted review and evaluation of designated aspects.

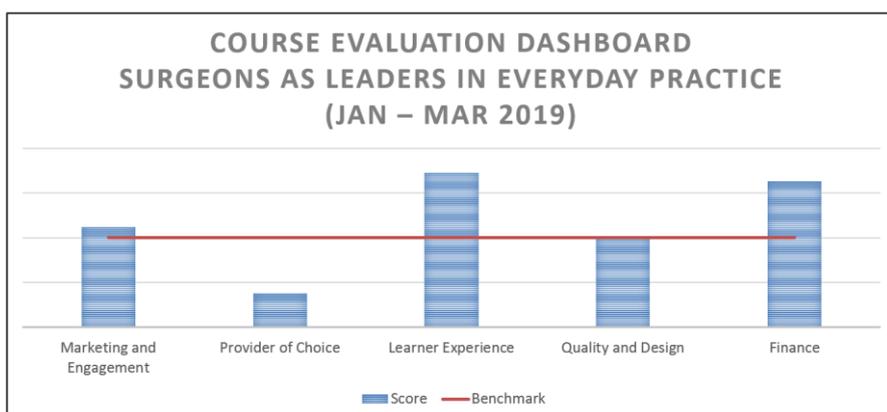


Figure 1 Course evaluation dashboard

Condition 18	In conjunction with the specialty training boards, develop a policy to manage the situation whereby a trainee has been inadvertently identified as a result of providing feedback. CLOSED
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Condition 19	Establish methods to seek confidential feedback from supervisors of training, across the surgical specialties, to contribute to the monitoring and development of the training program. To be met by: 2019
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As part of the further development of an overarching framework for monitoring and evaluation of surgical training (see Condition 17), RACS will be working with our boards to establish an overarching supervisor feedback mechanism. This will provide RACS and therefore the AMC with further assurances about the quality of and support for RACS supervisors. The approach to collecting confidential feedback from supervisors about their experiences will build upon work already in progress by a number of RACS STBs.

RACS STBs in general surgery Au and neurosurgery already receive feedback from training supervisors, as does the AOA FTC. RACS STBs in P&RS Au and urology are currently considering confidential feedback

mechanisms for training supervisors. The RACS STB in urology will introduce an annual confidential survey for Training Supervisors to provide feedback on all aspects of the training program.

The initiative to develop an overarching process for obtaining confidential information from RACS supervisors is part of a wider body of work to develop a supportive curriculum for RACS supervisors. The new Supervision Curriculum Framework is being developed to help RACS supervisors achieve the RACS Standards for Supervision. This will include bringing together all the support RACS already provides to RACS supervisors in their fundamental and central role in training.

Condition 20	<p>Develop and implement completely confidential and safe processes for obtaining—and acting on—regular, systematic feedback from trainees on the quality of supervision, training and clinical experience.</p> <p>To be met by: 2019</p>
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The landscape for the development and implementation of completely confidential and safe processes for obtaining and acting on regular, systematic feedback from trainees on the quality of supervision, training and clinical experience has changed.

The Medical Board of Australia has confirmed the launch of the Medical Training Survey (MTS) nationally in August 2019. This raises some challenges for RACS in determining next steps. RACS is currently reflecting on the work that has been done to date and considering options, as RACS is a binational college and the MTS will not be rolled out in New Zealand.

Despite concerns about survey fatigue, RACS is likely to develop our work involving RACSTA, including redesigning the RACSTA trainee survey to better refine data collection in light of the MTS and the Australian Orthopaedic Registrars Association (AORA) trainee survey in Australia. RACS hopes to utilise the feedback survey using a ‘dashboard’ approach to inform hospital training post accreditation. RACS is also investigating innovative ways to use the data to inform policy to safeguard trainees who provide feedback, alongside our complaints mechanisms.

RACS STBs in general surgery Au, neurosurgery and P&RS Au all regularly collect confidential feedback from trainees, as does the AOA FTC. Some RACS STBs ask trainees to complete the RACSTA end-of-rotation survey, which is anonymous. The RACS STB in urology has an Annual Training Post Assessment Form which is anonymous, however, responses can be identified by post, year, and SET level. The RACS STB in vascular surgery interviews every trainee annually at the skills course to seek feedback on all aspects of their surgical training.

Condition 21	<p>Develop formal consultation methods and regularly collect feedback on the surgical training program from non-surgical health professionals, healthcare administrators, and consumer and community representatives.</p> <p>To be met by: 2020</p>
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RACS is committed to engaging more formally and regularly with non-surgical health professionals, healthcare administrators and consumer and community representatives in relation to our training programs. In response to Condition 6, RACS presents the work that has been undertaken to engage wider groups in the activities of the College more broadly.

In respect specifically to RACS surgical training programs, one recent example includes a survey of junior doctors and medical students to canvass barriers and drivers that affect women’s decisions about whether or not to pursue careers in surgery. The survey included questions on perceptions of the surgical training program. Almost 1,700 responses were received. Results will inform strategic directions and communications regarding the surgical training program.

RACS is considering establishing a Patient and Public Involvement (PPI) Forum. This group would bring together community representatives who are currently involved in supporting RACS, in part to collaborate and support each other, but also to stimulate further development in this domain. The forum would consider and advise RACS on scope of membership and activities, including providing direct involvement in feedback regarding RACS' surgical training programs.

RACS is also exploring the use of multi-source feedback (MSF) more widely across all of our surgical programs in the evaluation of trainees (see recommendation KK) which will involve surgical team members, other health professionals and administrators.

RACS STB in cardiothoracic surgery, OHNS, paediatric surgery, P&RS Au, and urology involve non-surgical health professionals in their 360-degree feedback of trainees. As part of the AOA and RACS STB in P&RS NZ accreditation processes, accreditation review teams consult with staff at all levels at training sites, including hospital administration. RACS STB in paediatric surgery has consulted consumer groups for feedback on their perceptions of trainees. RACS STB in urology training post inspections are performed regularly and include discussions encompassing all aspects of the training program with hospital administration, nursing staff and, where indicated, other relevant parties. RACS specialties also seek feedback from external members on RACS STBs.

Condition 22	Report the results of monitoring and evaluation through governance and administrative structures, and to external stakeholders. It will be important to ensure that results are made available to all those who provided feedback. To be met by: 2020
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Governance oversight of RACS educational programs including training resides with the RACS Education Board, as delegated by RACS Council. Currently regular reporting is submitted to the Board from all educational sub-committees including RACS STBs [through the Board of Surgical Education and Training (BSET)], IMG Committee, Prevocational and Skills Education Committee. Reporting frameworks are regularly updated in response to need such as for example around complaints reporting, and initiatives in the Building respect, improving patient safety program.

Strengthening of reporting governance data is underway. Current examples of reporting results of monitoring and evaluation include:

- Barriers and Drivers for Women: The findings of the 'Barriers and Drivers for Women' survey will be reported on the RACS website in late 2019. Initial results will be presented to RACS staff in July 2019. Formal reports on findings will be made through RACS governance structures, commencing with the Building respect, improving patient safety committee.
- RACS education portfolio is conducting a review of online survey tools and processes in use throughout the College to streamline and improve survey processes, including reporting of outcomes. A priority is to ensure that survey results are made available to all those who provide feedback.
- The RACS STB in neurosurgery presents de-identified reports to the Neurosurgery Training Board every six months. The AOA FTC presents outcomes of regular feedback surveys to Regional and Federal Training committees and to the AOA Board for response and action as required.

Condition 23	Develop and implement an action plan in response to the 2016 Leaving Surgical Training study. To be met by: 2019
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RACS has met this condition by developing and implementing an action plan in response to the core areas identified in 2016 *Leaving Surgical Training* study. Three overarching themes were identified: Inflexibility in the

training program, an unacceptable culture in which to learn; surgery being the wrong career choice including surgery as an unattractive lifestyle choice.

The RACS action plan in response has included: implementation of the Building Respect Improving Patient Safety Action plan, characterized by a sustained focus on the prevention and early intervention in the areas of discrimination, bullying and sexual harassment; cultural change in the practice of surgery and thus, the learning environment as a key long-term outcome.

Findings from two subsequent studies to inform a response to women leaving surgical training at higher rates than men have since been completed (Liang, Dornan and Nestel, Lancet, 2019 and Hutchinson, unpublished PhD thesis, 2019). Their findings further reinforce the significance of cultural issues and thus offer further impetus to act on discrimination bullying and sexual harassment (DBSH). In addition, it should be noted that RACS has commenced work to identify the barriers to women selecting surgery as their medical specialty. Understanding and responding to these issues will assist in our goal of achieving better gender equity in surgery and the benefits which accrue from having a diverse and representative workforce. The results of this research will be available to RACS by the end of 2019

Statistics and annual updates

A summary of evaluations undertaken and the main issues arising from evaluations with RACS' response to issues raised, including how RACS reports back to stakeholders is presented in Appendix 7, Table 17.

Standard 7: Issues relating to trainees

Areas covered by this standard: admission policy and selection; trainee participation in education provider governance; communication with trainees; trainee wellbeing; resolution of training problems and disputes

Summary of significant developments

RACS is partnering with Monash Institute for Health and Clinical Education to pilot Situational Judgement Tests (SJTs) in selection in 2019. A workshop with representation from all specialities was conducted in February. Participants developed SJT scenarios and responses, which were reviewed and implemented during the 2019 selection process. Outcomes of the pilot will inform selection activities in 2020.

Selection interviewer training was conducted by RACS education staff for three specialty training boards (STBs) in June 2019.

Recommendations for improvement

OO	<p>In relation to selection into the surgical training programs:</p> <ul style="list-style-type: none"> (i) Evaluate the objectives of the selection process to ensure they are both clear and consistent across all surgical training programs. (ii) Develop a process to ensure that updates and changes to entry prerequisites undergo a consultation process, and provide appropriate lead time for prospective applicants to meet them. (iii) Explore the means by which prevocational work performance and technical ability may be more appropriately assessed as part of the selection process. <p>Examine the key discriminators (e.g. academic record, research, experience, interview performance) in the current selection process and whether these are the most relevant for predicting performance both as a trainee and as specialist</p>
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The 2019/2020 RACS Policy review, in conjunction with the service level agreements with each specialty, are anticipated to ensure consultation on changes in process for entry prerequisites provide appropriate lead time; some progress in this area has already been achieved. For example, RACS STBs in OHNS, P&RS Au, and urology have all made changes to selection prerequisites which were advertised with sufficient lead time for potential applicants to meet them. The RACS STB in general surgery Au and the AOA FTC provide at least 12 months' notice of major changes to minimum eligibility.

In part response to Conditions 5 and 24, RACS has recently developed and piloted SJTs as a selection tool for SET. It is anticipated that SJTs will become part of the RACS SET selection process from 2020.

Additionally, several RACS STBs have reviewed their selection tool weightings to ensure that more emphasis is placed on tools with better predictive ability (e.g. the multi-mini interview). Some specialties, including orthopaedic surgery, have ceased using the Curriculum Vitae (CV) to rank applicants and are instead using a minimum score on this tool as a hurdle requirement for selection

PP	Implement a program to increase awareness of the presence and role of the RACS Trainees' Association (RACSTA).
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The RACS Trainee Association (RACSTA) continues as a committee of RACS and has voting members on the Board of Surgical Education and Training (BSET), the Education Board (EB) and the RACS Council. The RACSTA committee has dedicated administrative support and will again hold its annual RACSTA Induction Conference in October 2019.

Activity against conditions

Condition 24	Further develop the selection policies for each surgical training program, particularly with regard to the provision of transparent scoring of each element in the curriculum vitae and the standardisation in the structure of referee reports. To be met by: 2020
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In response to this condition, RACS STBs are reviewing their Selection Regulations again in 2019. These will need to be approved by the EB Executive by October 2019. No new regulations will be approved without there being evidence of transparency in regard to scoring of each element in the curriculum vitae and the standardisation in the structure of referee reports. This will be met for 2020 in readiness for the 2021 RACS trainee intake.

Significant progress has already been made. Most RACS STBs already have transparent scoring guidelines currently available on Specialty Society and Association websites. However, some of the RACS STBs have made changes to their selection tools since 2018. RACS STB in cardiothoracic surgery have updated their CV scoring, and the AOA FTC now includes transparent scoring for the CV in the Selection Regulations. Also, the AOA FTC no longer uses the CV score to rank applicants for interview, and instead a minimum score on this tool is considered an eligibility requirement for progression to interview. The RACS STB in general surgery NZ have changed the wording of their referee report questions to get first person responses from referees. This has led to a wider distribution of scores on this tool, with far fewer candidates receiving scores of 100%. The RACS STB in orthopaedic surgery NZ have also reviewed their selection process, changes have been made to application process, scoring, and referee reports. The RACS STB in OHNS now include telephone interviews with referees to provide strength to the selection process.

Condition 25	Clearly document and make publicly available the standard of entry into each surgical training program. CLOSED
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Condition 26	Develop a policy that leads to the increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees in each surgical training program. To be met by: 2019
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RACS has met this condition with the publication of the RACS Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative Policy and early signs of its impact. RACS aims to increase the number of Aboriginal and Torres Strait Islander surgeons in the Fellowship to a minimum 5% of registered Aboriginal and Torres Strait Islander medical practitioners.

The recruitment and selection into surgical training of Aboriginal, Torres Strait Islander and Māori medical students and doctors is growing. In 2018 two Aboriginal applicants and seven Māori applicants were selected into SET. At present RACS has at least two Aboriginal and eleven Māori Fellows who have self-identified. The Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative has been implemented by eight of nine STBs. The first trainee selected as part of the initiative will be starting cardiothoracic surgery training in 2019.

Further initiatives include meetings between the Māori Health Advisory Group and the Chairs of the RACS NZ Boards. The purpose has been to collaborate and develop a framework to progress the development of appropriate selection processes, including giving recognition to skills in te reo (Māori language) and tikanga (Māori cultural practices), as well as cultural competency training for trainees and selectors. In 2019, 15 scholarships and awards were awarded to Aboriginal and Torres Strait Islander and Māori recipients. This

included: six Annual Scientific Congress (ASC) awards, two ASC Peer Supporter, six Career Enhancement scholarships, and one Aboriginal and Torres Strait Islander Final Year Medical Student Career Enhancement scholarship.

RACS will continue to monitor and evaluate the impact of the policy including the increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees in each of the RACS surgical training program. This will be a long-term initiative and part of the overarching evaluation program (Condition 17).

The RACS STBs in cardiothoracic surgery, general surgery Au, OHNS, paediatric surgery, P&RS Au, urology and the AOA Federal Training Committee have implemented the RACS Aboriginal and Torres Strait Islander Surgical Trainee Selection Initiative. The RACS STBs in general surgery NZ and P&RS NZ have not reserved training positions for Māori candidates as the agreed approach is to recognise and assign value within selection processes to cultural elements and knowledge that Māori applicants bring, and also to support Māori doctors considering applying to SET to achieve CV, referee and interview scores that increase the likelihood of their being selected. Both specialties report that they are considering ways to increase Māori representation in selection.

Condition 27	Promote and monitor the Diversity and Inclusion Plan through the College and specialty training boards to ensure there are no structural impediments to a diversity of applicants applying for, and selection into, all specialty training programs. To be met by: 2019
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RACS STBs have taken significant steps to meet this condition. The RACS STB in general surgery Au allocated additional points for applicants with surgical rural experience. The RACS STB in general surgery NZ will be working with the RACS Māori Health Advisory Group and Māori Health Project Officer to review other ways to improve Māori presentation as candidates. The RACS STB in general surgery NZ also allocates additional points on the CV for training exposure in rural/small provincial hospitals.

AOA FTC has identified barriers to a career in orthopaedic surgery for female doctors and have organised a series of 'Women in Orthopaedics' workshops around the country. The AOA FTC also reports that for the first time in 2018, almost 50% of orthopaedic surgery Au interviewers for the selection process were female, and 23% of successful applicants for the intake were female. The RACS STB in OHNS reports that trainees commencing in 2019 were 53% male (9) and 47% female (8), which is an improvement on previous years. The RACS STB in P&RS NZ has good cultural and gender diversity amongst trainees and the Board; 42% of trainees are female; 36% of Board members are females and 40% of supervisors are females.

Representatives from the RACS STB in P&RS Au have delivered presentations to medical students on the pathway to training and subsequent career in plastic surgery including issues on diversity and inclusion. The RACS STB in urology indicated that there is female representation on their Board, selection sub-committee and many of the interview panels, and interviewer orientation and training is carried out where the issue of unconscious bias is discussed.

Selection interviewer training, including reference to unconscious bias was conducted for three STBs in June 2019.

Condition 28	Increase transparency in setting and reviewing fees for training, assessments and training courses, while also seeking to contain the costs of training for trainees and specialist international medical graduates. To be met by: 2019
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In 2019, RACS engaged with KPMG to complete an internal control and risk assessment of the training fee structure, including an end-to-end process review of the billing process. This has been implemented in part to increase transparency in setting and reviewing fees for training, assessments and training courses, while also seeking to contain the costs of training for trainees and specialist international medical graduates.

Most specialties set training fees on a cost recovery basis and increases in fees are in line with increases in CPI. The RACS STB in general surgery NZ indicated that explanations for increases above CPI are routinely communicated to trainees. An open forum with trainees was held by the RACS STB in P&RS Au in March 2019, and the Australian Society of Plastic Surgeons (ASPS) CEO followed this up on in April 2019 with a formal letter that clearly and transparently outlines the activity-based costing and fee setting processes followed by ASPS, in its support of the RACS STB in P&RS Au.

Condition 29	Address trainee concerns about being able to raise issues and resolve disputes during training by ensuring there are mechanisms for trainees to do so without jeopardising their ongoing participation in the training program. To be met by: 2019
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RACS considers that Condition 29 has now been met through a number of important initiatives.

First, complaints from trainees directly to RACS are respectfully addressed through a weekly Triage process, where all complaints are considered. Triage is a multi-agency group involving educational, legal and surgical staff actioning all complaints under the leadership of the Deputy CEO.

When trainees raise concerns related to the behaviour of a RACS surgeon, these complaints are either referred to the appropriate jurisdiction, for example AHPRA, with trainee permission, or the College engages with the Fellow using interventions based on the Vanderbilt principles. Support through a third-party confidential counselling service is also provided to trainees.

Second, in July 2019, the EB Executive approved a new policy, *Challenging a RACS decision*, to cover all RACS decisions that might be challenged (Appendix 2). This includes all decisions made by our STBs. Processes are currently being developed in support of the new policy. Implementation will be confirmed by Council in October 2019.

The policy will support and guide RACS trainees through a fair and transparent process to resolve disputes during training. RACS STBs will be covered by RACS indemnity insurance once they adopt the new policy and RRA processes. (Also see response to Condition 3).

Statistics and annual updates

Table 6, Table 7 and Table 8 draw on data provided in the RACS 2018 *Activities Report* (Appendix 8). The [Activities Report](#) also presents data on additional facets of training. RACS included an optional question for the first time in SET registration 2017 to ascertain whether applicants commencing training in 2018 identified as Aboriginal, Torres Strait Islander or Māori. As this question was not mandatory, data may not accurately reflect the Aboriginal, Torres Strait Islander or Māori status of all SET trainees.

Trainees entering, completing and currently in training

RACS reports the number of trainees entering the training program during 2018 in Table 6; the number of trainees who completed training in each program in 2018 in Table 7; and the number and gender of trainees undertaking each college training program in 2018 in Table 8.

Table 6 Number of trainees entering SET January – December 2018

Training program	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	O/S	Total
Cardiothoracic Surgery	0	1	0	1	1	0	0	0	0	0	3
General Surgery	3	42	5	21	10	0	32	11	15	0	139
Neurosurgery	0	1	0	3	0	0	2	1	0	0	7
Orthopaedic Surgery	0	8	0	8	2	1	9	3	15	0	46
Otolaryngology Head and Neck Surgery	0	2	0	5	4	0	4	1	3	0	19
Paediatric Surgery	0	0	0	1	0	0	0	0	0	0	1
Plastic and Reconstructive Surgery	0	4	0	6	1	0	5	1	3	0	20
Urology	0	6	0	2	1	0	5	3	3	0	20
Vascular Surgery	0	2	0	1	0	0	3	1	0	0	7
Total	3	66	5	48	19	1	60	21	39	0	262
Aboriginal, Torres Strait Islander and Māori trainees		1		1					1		3

Table 7 Number of SET trainees completing training and obtaining Fellowship January – December 2018

Training program	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	NZ	O/S	Total
Cardiothoracic Surgery	0	0	0	1	0	0	1	0	0	2	4
General Surgery	1	17	0	13	4	1	14	3	7	1	61
Neurosurgery	0	4	0	0	1	0	0	0	0	0	5
Orthopaedic Surgery	1	15	1	10	2	0	11	3	14	1	58
Otolaryngology Head and Neck Surgery	1	1	0	4	0	0	3	1	4	1	15
Paediatric Surgery	0	1	0	0	0	0	0	0	0	0	1
Plastic and Reconstructive Surgery	0	5	0	1	3	0	4	3	0	5	21
Urology	0	5	0	2	1	0	2	1	2	4	17
Vascular Surgery	1	3	0	2	1	0	1	0	1	0	9
Total	4	51	1	33	12	1	36	11	28	14	191
Aboriginal and Torres Strait Islander and Māori trainees	Data not collected										

Table 8 Number and gender of trainees per specialty undertaking SET January – December 2018

Training program	Male	Female	Unspecified	Total
Cardiothoracic Surgery	28	10	-	38
General Surgery	294	149	-	443
Neurosurgery	40	14	-	54
Orthopaedic Surgery	236	38	-	274
Otolaryngology Head and Neck Surgery	60	24	-	84
Paediatric Surgery	16	19	-	35
Plastic and Reconstructive Surgery	64	31	-	95
Urology	78	21	-	99
Vascular Surgery	33	12	-	45
Total	894	318		1167

Selection into training

Changes to policies and procedures. Two key changes to selection policies occurred in the reporting period. These are summarised in Table 9. All RACS STBs update regulations annually.

Table 9 Changes to policies

Policy	Description of changes
ETA_SET_005 Selection into Surgical Education and Training	<p>Inclusion of Clause 3.2 Selection Instruments. Principle that addresses research and evaluation of new selection tools and the pilot testing to establish their efficacy. See Appendix 9.</p> <p>All RACS STBs updated 2019 Regulations (published November 2018) with the same clause</p>
ETA-SET-028 Surgical Education and Training Fee	<p>Council approved an update to Clause 3.5.3 to reflect a fixed rate instalment processing fee, previously calculated at a percentage of the training fee. See Appendix 10.</p>

Standard 8: Implementing the program – delivery of education and accreditation of training sites

Areas covered by this standard: supervisory and educational roles, and training sites and posts

Summary of significant developments

Following the 2018 ‘roadshow’ between RACS and our partners, the Specialty Societies and Associations, an initiative was developed called the Speciality Training Board (STB) Program. The program contains 14 areas that RACS and the Specialty Societies and Associations have identified as requiring greater support.

In 2018-19, the first three initiatives were prioritised and developed. The initiatives include development of resources for the induction of members of RACS STBs, with particular focus on governance, resources to better support RACS supervisors, and enhanced hospital training post accreditation support.

Recommendations for improvement

QQ	Develop a policy that is adhered to by all specialty training boards which stipulates the minimum advanced notice required prior to requiring commencement of new rotations and which also minimises the number of interstate /international rotations.
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A policy that stipulates the minimum notice required prior to commencement of new rotations and which also minimises the number of interstate and/or international rotations will be considered as part of the 2019/2020 policy review, in conjunction with the specialty service agreements. These are expected to be concluded by mid-2020. Specifically, RACS STB in general surgery Au generally does not rotate trainees interstate (in Australia), with the exception of a small number of trainees who rotate through Tasmania, NT, and ACT, and who typically request to be allocated to these networks. The AOA FTC has developed a new two-preference system for selection, whereby applicants select their top two geographic preferences. It is anticipated that this will reduce the number of interstate transfers.

Minimising interstate rotations needs to be carefully balanced against the desirability for all trainees to gain exposure to rural and remote training experiences to enhance the likelihood of choosing rural or regional careers.

RR	Work with the jurisdictions to assist in preventing the loss of employment benefits when trainees transfer between jurisdictions.
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Discussions are underway with various Australian state/territory jurisdictions to try to prevent the loss of employment benefits when trainees transfer between jurisdictions. NSW Health presented to RACS Board of Surgical Education and Training (BSET) in June 2019 about work to protect trainees’ employment benefits through longer employment contracts (typically now five years) and the protection of employment rights such as parental, annual and sick leave. It is proposed that RACS STBs work with NSW Health to ensure this happens in NSW. RACS, in concert with the AMA and other specialist medical colleges, has also been lobbying individual State Health Ministers, the Council of Australian Governments (COAG), the Australian Health Ministers’ Advisory Council and Hon Greg Hunt MP regarding this important area.

The collaboration with NSW Health is already working well with the RACS STB in P&RS Au and the AOA FTC. The RACS STB in P&RS Au has worked with hospitals to ensure a new contractual arrangement is in place for the next 2019 rotation and the outcome of this new arrangement will be tested at forthcoming inspections.

SS	Consider how to expand the surgical training programs in rural and regional locations.
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The federal Department of Health provides STP funding to RACS to manage and fund 70 specialist training positions in Australia across eight specialties, via individual contracts with funded and accredited hospitals, as well as support projects to aid trainees in these positions. The new 2018-20 Standard Funding Agreement of this program includes increased focus on supporting regional, rural and remote training.

In addition, several RACS specialties have taken steps to encourage trainees to take up posts in rural and regional locations. The RACS STBs in general surgery Au and general surgery NZ award CV points in selection to SET for time spent in rural centres, and a trainee induction day presents benefits of working in smaller centres. They also encourage smaller centres to apply for accreditation. The RACS STB in OHNS is reviewing rural and regional opportunities – currently there are accredited posts in Darwin and Toowoomba. The AOA’s Rural Surgeons Committee has developed a proposal for a Rural Fellowship position that could be made available to trainees during the Transition to Practice Stage of Training. In New Zealand, the STBs in general surgery, orthopaedic surgery, OHNS and urology all have accredited training positions in provincial centres.

TT	Support collaboration amongst the specialty training boards to develop common accreditation processes and share relevant information.
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Supporting collaboration amongst the RACS STBs to develop common accreditation processes and share relevant information will be considered as part of the 2019/2020 policy review in conjunction with the specialty service agreements. In the meantime, RACS is developing a common training post accreditation process and will share information through a new training/support program for our STBs. The online and face-to-face program will primarily focus on: relieving the administrative burden - reviewing existing criteria and developing reporting templates; a centralised system to capture hospitals’ generic criteria; communication of ‘low level’ issues between all RACS specialties; roles and responsibilities - defined process of required standards and graded responses; consequences of standards not being met; inspector support mechanisms - how to address concerns, early action, information gathering and detailed feedback without privacy breach; and developing a central point for complaints management.

Activity against conditions

Condition 30	Mandate cultural safety training for all supervisors, clinical trainers and assessors. To be met by: 2020
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The cultural awareness and safety project as described in Condition 11, will embed cultural awareness and safety into the SET program. This project is also informing the resources being prepared for supervisors as part of the Supervisor Curriculum Framework project, as described in Condition 19. Cultural awareness and safety training will be part of the expectation of good supervisor practice.

RACS has not yet mandated cultural safety training for all RACS supervisors, trainers and assessors because many hospitals already deliver cultural competency training, tailored to local conditions, as part of their requirements for employment. RACS will undertake a scoping exercise in 2019-20 to understand the prevalence of such cultural safety training and will consider the comparability with RACS requirements and preferred delivery models (e.g. face-to-face or online delivery by RACS, by employers, or by external agencies).

Condition 31	<p>In conjunction with the specialty training boards, finalise the supervision standards and the process for reviewing supervisor performance and implement across all specialty training programs.</p> <p>To be met by: 2021</p>
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RACS has published the *Standards for Supervision* (as discussed in Condition 19) on the RACS website; this is presented in Appendix 11.

This resource sets out the role and principal responsibilities of supervisors in RACS training programs by aligning supervisor responsibilities to RACS competencies and by providing resources for supervisors.

RACS is exploring ways in which the process for reviewing supervisor performance can be developed and implemented across all RACS specialty training programs. As discussed in Condition 19, the initiative to develop an overarching process for obtaining confidential information about RACS Supervisors is part of a wider body of work to develop a supportive curriculum for RACS supervisors. The new *Supervision Curriculum Framework* is being developed to help RACS Supervisors achieve the RACS *Standards for Supervision* and will ideally include a feedback loop to review supervisor performance while providing supportive, developmental feedback to individual supervisors.

Condition 32	<p>Promote the Building Respect, Improving Patient Safety program and encourage the positive participation of all fellows and trainees, including supporting all surgeons to “call out” bad behaviour in work and training.</p> <p>CLOSED</p>
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Condition 33	<p>In the hospital and training post accreditation standards for all surgical training programs include a requirement that sites demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence.</p> <p>To be met by: 2019</p>
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The RACS Hospital Accreditation Criteria are currently under review and will be updated to include a requirement that sites demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence.

RACS is working with the Australian Indigenous Doctors’ Association (AIDA) regarding their roll-out of a face-to-face Aboriginal and Torres Strait Islander Health in Clinical Practice training program that would be tailored for the needs of surgeons. As part of the Continuing Professional Development (CPD) program, Aboriginal and Torres Strait Islander Health and Cultural Competence e-modules have been promoted to Fellows.

Most RACS STBs are awaiting the revision of RACS’ training post accreditation standards. The RACS STB in P&RS Au has changed Training Post Accreditation Regulations to include specific reference for training sites to demonstrate a commitment to Aboriginal and Torres Strait Islander and/or Māori cultural competence.

Statistics and annual updates

Accreditation activities, including sites visited, sites/posts accredited or not accredited, are presented in Table 10.

Table 10 Site accreditation activities January 2018 – December 2018

Number of Sites/Posts	ACT	QLD	NSW	NT	SA	TAS	VIC	WA	NZ	Total
Visited	2	9	44	0	6	3	14	4	11	93
Accredited	10	32	147	0	32	10	30	15	26	302
Not accredited	0	1	0	1	0	0	5	0	4	11

Standard 9: Continuing professional development, further training and remediation

Areas covered by this standard: continuing professional development; further training of individual specialists; remediation

Summary of significant developments

RACS has commenced a review of the Continuing Professional Development (CPD) Framework. A working party has been established to provide recommendations on all aspects of the program including the overarching framework, standards and policy, education to support CPD participation and a revised technology platform. The new program will incorporate elements of the Medical Board of Australia's (MBA) Professional Performance Framework and the Medical Council of New Zealand (MCNZ) Recertification and Professional Development requirements.

The RACS review of the *Surgical Competence and Performance Guide* is also underway; it is anticipated this will be complete by the end of 2019.

Recommendations for improvement

UU	Implement a mechanism for the newly established CPD Audit Working Group to provide more robust feedback to Fellows, with a focus on the breadth of surgeons' individual practice.
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A CPD Standard for Surgical Audit and Peer Review has been drafted and is under review by the College's Surgical Audit Committee. The CPD Standard is expected to be finalised by the end of 2019, and will be enforceable under the revised CPD Framework.

Scoping has commenced to support Fellows with setting up their CPD profile ahead of release of the new CPD Framework. This will include an approach to gain a better understanding of the breadth of each surgeon's individual practice to align and customise their CPD participation. It is anticipated that this will be available to Fellows in early 2020.

VV	As part of the reflective practice category consider including cultural competence as an area of reflection. SATISFIED AND CLOSED
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WW	Explore the College's role in identifying the poorly performing fellow.
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The RACS multi-source feedback (MSF) model is under review, including ensuring alignment with best practice and developing a robust model of facilitated feedback across trainee and post-Fellowship cohorts. RACS is also reviewing the complaints processes, with an emphasis on early intervention, mediation and peer to peer engagement.

On completion of the Surgical Audit and Peer Review standard, the *Surgical Audit Guide* will be updated and will incorporate a revised process for managing an outlier.

The RACS Code of Conduct is scheduled for review in 2020.

Activity against conditions

No conditions to report.

Statistics and annual updates

The number and proportion of college Fellows participating in and meeting the requirements of the college's continuing professional development programs are reported in Table 11 and Table 12. Table 11 shows that 99% (n = 6,459) of RACS Fellows are CPD compliant (n = 6,511). Table 12 shows that 82% (n = 63) of non-fellows are CPD compliant (n = 77).

Table 11 Fellows participating in and meeting the RACS CPD program requirements January 2018 – December 2018

Number of Fellows			Fellowship participating in CPD					
Australia	New Zealand	Other	Australia		New Zealand		Other	
			Total no.	Total %	Total no.	Total %	Total no.	Total %
5348	830	333	5318	99	819	99	322	96

Table 12 Non-fellows participating in and meeting the RACS CPD program requirements

Number			Non Fellowship participating in CPD					
Australia	New Zealand	Other	Australia		New Zealand		Other	
			Total no.	Total %	Total no.	Total %	Total no.	Total %
12	63	2	8	67	54	86	1	50

Standard 10: Assessment of specialist international medical graduates

Areas covered by this standard: assessment framework; assessment methods; assessment decision; communication with specialist international medical graduate applicants

Summary of significant developments

The RACS International Medical Graduate (IMG) Committee has significantly progressed development of the 'External Validation of Professional Performance (EVOPP)' tool during 2018 and 2019. While EVOPP is still being piloted, RACS is confident that the EVOPP methodology is feasible and valid and is comparable to international best practice IMG assessment.

RACS is working with the Medical Council of New Zealand (MCNZ) to align RACS and MCNZ IMG assessment processes to facilitate a pathway to FRACS for IMGs in New Zealand, rather than their obtaining solely vocational registration.

Recommendations for improvement

XX	<p>Provide greater support for specialist's international medical graduate surgeons working towards specialist/vocational registration, and including access to educational resources, such as examination revision course, and other resources that are accessible to trainees.</p> <p>SATISFIED AND CLOSED</p>
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YY	<p>Make information available to future applicants that may allow them to assess the likelihood of their application achieving substantially or partially comparable status prior to them making a substantial financial payment that historical evidence might suggest is unlikely to succeed.</p>
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RACS considers that Recommendation YY has been met. As reported in 2018, RACS undertook a 5-year analysis of the outcomes of IMG assessments in Australia and this was published on the RACS website to enable IMGs to self-assess the likelihood of their application achieving substantially or partially comparable status prior to making an application. Overview information for IMGs available at <https://www.surgeons.org/imgs/img-overview>; self-assessment information is available at <https://www.surgeons.org/imgs/application-process>; policies, guidelines and forms for IMGs are available at <https://www.surgeons.org/imgs/contacts-guidelines-and-forms>.

Condition 34	<p>All College and Specialty Training Board SIMG assessment processes and associated documentation must reflect the Medical Board of Australia and Medical Council of New Zealand guidelines by ensuring that both training and post-training experience are appropriately considered in assessments of comparability.</p> <p>To be met by: 2019</p>
---------------------	--

RACS considers that Condition 34 has now been met. Following extensive discussions, including three meetings and three workshops in 2018, the IMG Committee developed a policy *Assessing an IMG's Comparability to an Australian and New Zealand Trained Surgical Specialist* (Appendix 12) to clearly define the process for assessing an IMG's comparability to an Australian and New Zealand trained surgical specialist. The policy was approved by the Board of Surgical Education and Training and published on [RACS website](#) in October 2018.

RACS now assesses IMGs' recency of practice, training program, and exit examination as well as:

- Postgraduate training and experience
- Depth and scope of practice
- Non-technical skills

Appendices are included in the policy to clearly define specialty-specific training requirements and specialty-specific requirements for depth and scope of practice. To assist assessors in assessing an IMG's comparability, in accordance with the new policy, the IMG Committee revised the document-based assessment proforma, the individual rating interview proforma, the interview summary assessment and final recommendation proforma, and the interview scenarios.

The process in New Zealand for advising the MCNZ on the suitability of IMGs for vocational registration, remains consistent with that acknowledged as fulfilling the MCNZ's expectations.

Condition 35	Develop and adopt alternative external assessment processes, such as workplace-based assessments, to replace the Fellowship Examination for selected specialist international medical graduates. To be met by: 2020
---------------------	--

The RACS IMG Committee has progressed development of the workplace-based assessment (WBA) tool during 2018 and 2019. RACS has completed:

- Review and analysis of international good practice, with particular learnings obtained from the Medical Council of New Zealand (MCNZ) Vocational Practice Assessment, the NZOA practice visit program, ANZCA's work-based assessments and remedial assessments undertaken by the health regulators.
- Development of an assessment process: the 'External Validation of Professional Performance (EVOPP)' by RACS' Principal Educator and Clinical Director.
- Delivery of two assessor training programs in 2018. Feedback received from attendees was positive regarding the proposed EVOPP process.
- Delivery of three pilot EVOPPs, in 2018 and 2019. Each two-day pilot is resource intensive to administer.
- RACS IMG Committee presented findings at June 2019 Board of Surgical Education and Training (BSET). The Committee proposed extending the process to new IMGs to extend the pilot process to IMGs from more countries and specialties. This will further test validity and reliability (without consequence for the IMGs pathway). Several IMGs have been approached but been hesitant to volunteer their time.

RACS is confident that the EVOPP methodology is feasible and valid and is comparable to international best practice IMG assessment.

Statistics and annual updates

The numbers of applicants and outcomes for IMG assessment processes for Fellowship for the last 12 months are reported in Table 13 and Table 14.

Table 13 Number of new applicants undertaking international medical graduate assessment (1/8/2018-31/7/2019)

Number of new applicants since last progress report	Australia	New Zealand
1 August 2018 – 31 July 2019	71	0

Table 14 Number of international medical graduate assessments for Fellowship (1/8/2018-31/7/2019)

Phase of IMG assessment	Australia	New Zealand
Initial Assessment	N/A	N/A
Interim Assessment Decision		
• Not Comparable	13	0
• Partially Comparable	26	0
• Substantially Comparable	10	0
Ongoing Assessment	64	0
Examination pending	20	0
Final Assessment	31	3
Total	164	3

Notes:

'Ongoing assessment' refers to IMGs under RACS' supervision.

'Examination pending' refers to IMGs who have completed their period of supervision but are yet to satisfy Fellowship Examination requirements.

'Final assessment' refers to IMGs who have completed all assessment requirements and have been admitted as Fellows of RACS.

Appendices



Strategic Plan
2019 - 2021
and Operations Plan 2019



ABOUT RACS

BACKGROUND

The Royal Australasian College of Surgeons (RACS) is committed to leading surgical standards, professionalism and education across Australia and New Zealand. It has a proud history of facilitating the training of new surgeons, ensuring the support and development of existing surgeons and leading advocacy around standards and patient care.

RACS represents the collective and national interests of Australian and New Zealand surgeons and also the specific needs and opportunities within the eight states and territories of Australia. Importantly, the targeted, localised functions are managed through the Australian State/Territory and New Zealand offices.

The RACS Strategy 2014-2018 advocated four key strategic pillars and objectives:

- To champion professionalism and standards in surgical practice and education
- To support and enhance the contribution of surgeons to the broader community
- To develop and maintain strong external relationships
- To ensure the most effective use of resources.

This work has provided an important basis on which RACS can confidently move forward into a new phase of development.

HEALTH SECTOR CONTEXT

Australia and New Zealand provide some of the best health systems in the world. There are, however, significant challenges facing healthcare. As people live longer and the incidence of non-communicable diseases increases, pressure intensifies on rising costs. Patient and family expectations are changing, shaped by seamless, digital experiences in other sectors. People want to be able to access healthcare in the way that best suits them – and have rapid access to the latest medical advances.

Current trends shaping the delivery of healthcare include:

1. Patient empowerment, education and transparency
2. Wellness and prevention
3. New models of integrated care
 - driven by outcomes-based funding and management
 - enabled by connected electronic health networks
 - and delivered by a health workforce that has the right capabilities.

A key focus for the sector is to develop innovative, cost-effective ways to deliver patient-centred, technology-enabled healthcare, both inside and outside of hospitals.

RACS STRATEGY IN 2019

The RACS Strategy 2019-2021 presents an opportunity to build on the past while preparing the profession of surgery for a dynamic future. It reinforces the focus on core education, training and advocacy programs, better supporting surgeons to deliver excellence in contemporary patient care. The strategy is underpinned by the established RACS Mission, Vision and Values.

MISSION

The leading advocate for surgical standards, education and professionalism in Australia and New Zealand.

VISION

Leading surgical performance, professionalism and improving patient care.

VALUES

Service, respect, integrity, compassion and collaboration

The continued relevance of the organisation's constitution is embedded in the strategy, enabling a confident pathway into the future.

It identifies three essential areas of purpose for RACS:

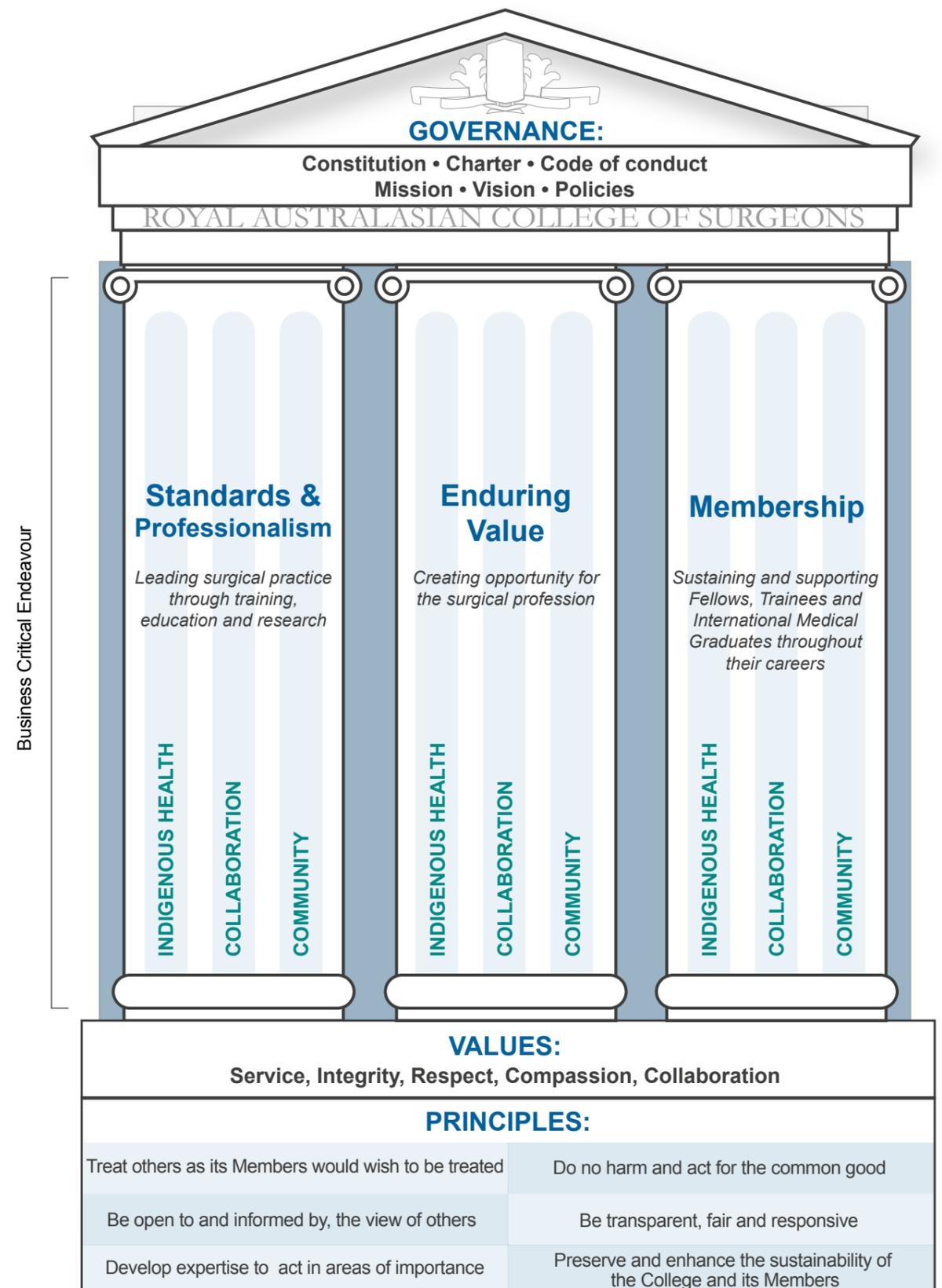
- Uphold standards
- Train the surgeons of the future
- Create enduring value for the profession.

These form the basis of the strategy and goals for the organisation:

- Standards and Professionalism – leading surgical practice through training, education and research
- Enduring Value – creating opportunity for the surgical profession
- Membership – sustaining and supporting Fellows, Trainees and International Medical Graduates throughout their careers.

RACS will prioritise Indigenous Health, building workforce and increasing services to better meet the health needs of Aboriginal and Torres Strait Island and Māori people. Focus is also on collaborating effectively with our partners and supporting the communities we serve.

The strategy is graphically represented in the opposite diagram:



OUR ORGANISATION IN 2019

RACS has moved to a structure of four portfolios:

- Fellowship – delivers a range of membership-based services as well as surgical standards and quality care processes and procedures, policy development and the recertification of Fellows
- Education – ensures the highest standard of safe, respectful and comprehensive surgical care through excellence in selection, training, professional development and continuous education
- Partnerships – develops and strengthens partnerships within the surgical community and the broader community it serves, to increase the impact and reach of surgical practice and care
- Operations – ensures the efficient management of all internal operations and resources of the College.

Through this structure, RACS aims to better focus on meeting the needs of Australia and New Zealand's health through meeting the needs of its membership by:

- Delivering contemporary training and education, taking account of new approaches to training and new ways of delivering surgical care
- Strengthening partnerships with surgical specialty societies
- Actively seeking external perspectives to align with best practice professional models and feedback to guide and improve
- Becoming the trusted voice in surgical practice and care across the region
- Providing services across the membership which add value to their clinical practice, professionalism and patient care
- Increasing operational efficiency and effectiveness which will ensure the long-term sustainability of the organisation.

OPERATIONAL FOCUS IN 2019

The coming year is both a time of consolidation following organisational structure changes in 2018 and of building to maximise the opportunities for RACS and its membership. A united approach with our surgical speciality societies will be crucial to achieve and embed change.

Priorities for 2019 are to:

- Deliver on the core business of training, education and advocacy
- Build confidence of Trainees in the training programs
- Provide value for members and improve member engagement
- Improve efficiency of the organisation and streamline governance structure

- Maintain and develop professional standards including CPD
- Influence health policy (as it applies to surgery and patient care)
- Improve access to surgery across RACS jurisdictions and regions
- Extend focus and action on indigenous health.

Collaboration across the organisation and with partner organisations will be maximised across all areas of work. Flagship projects have been identified which are of significant importance to the organisation and purposefully sit across all portfolios. The delivery will ensure teamwork and a commitment to outcomes. These focus on technology, training, CPD and membership services.

OUR SURGEONS

RACS is focused on supporting all current and future surgeons within a sustainable, respectful and innovative health care environment. The focus will be on developing a better understanding of and responding to the needs of all Trainees, Fellows and IMGs.

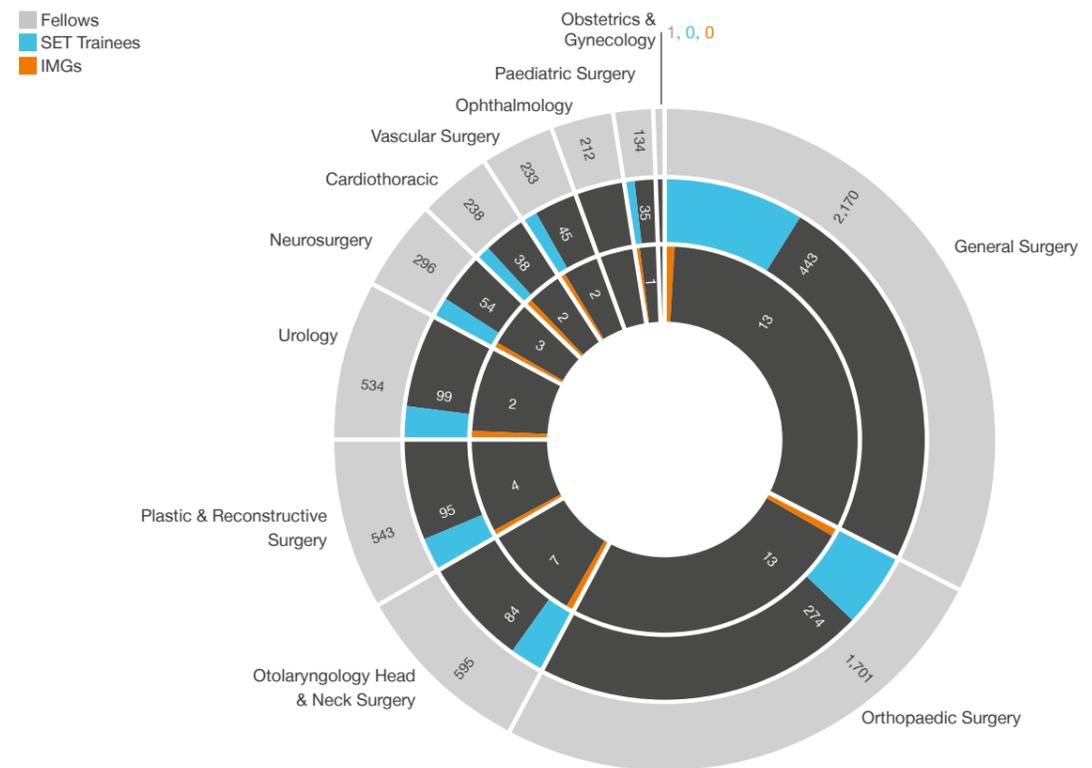
The membership of RACS continues to strengthen by specialty and region (as outlined in the following graphs).

OUR TEAM

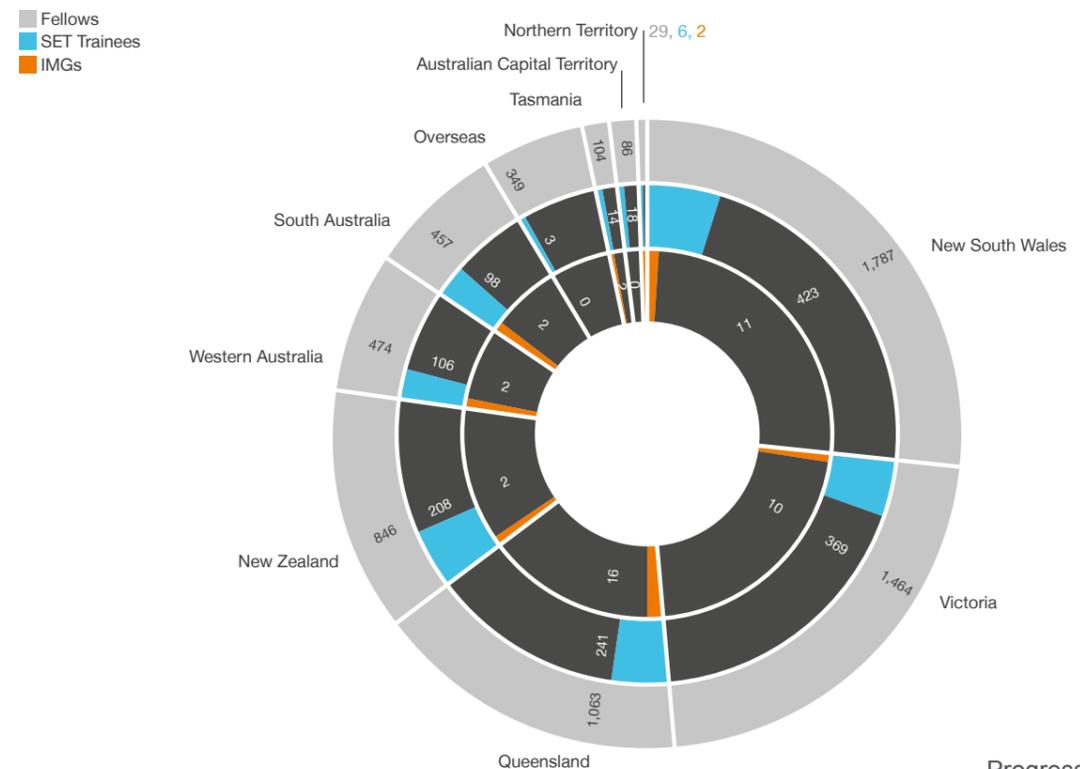
The engagement of RACS staff is key to its success. As a learning organisation, there is a focus on the support and development of staff to optimise their capability in a values-driven and service-delivery environment. Aligning work and priorities to the strategy will enable teams to focus on delivering outcomes which ultimately benefit the membership.

MEMBERS

MEMBERS BY SPECIALITY



MEMBERS BY REGION



PORTFOLIO OPERATIONAL PLANS 2019

High level directions for each portfolio are outlined below, providing a statement of goals and activities as well as how each will be measured to ensure focus on achievement and outcomes.

FELLOWSHIP

STANDARDS AND PROFESSIONALISM

GOALS

RACS is a leader in the development and maintenance of Professional standards

OBJECTIVES

To reposition Continuing Professional Development (CPD) as a service to Fellows.



KEY ACTIONS

Ensure current CPD maintained through the review phase

Plan, design and develop new CPD Program and IT Platform

Ensure successful Professional Conduct Committee process

MEASURING SUCCESS

CPD compliance
New CPD program aligned to Fellows' needs and requirements of regulators
Feedback on Professional Conduct Committee process

To influence improvement in surgical standards through the provision of qualified advice across RACS (in conjunction with Australian State, Territory, and New Zealand committees and Specialty Societies).



Work with governments (Australia, New Zealand, States and Territories), health organisations and consumer bodies to lead future planning and standards for surgery.

Development of policy and position papers in line with RACS priorities.

Response to formal and informal submissions
Outcomes achieved in line with plans for each identified

To maintain and develop key stakeholder relationships across RACS and with Specialty Societies.



Collaborate across RACS and with Speciality Societies to align expectations and shared opportunities

Support the Building Respect Improving Patient Safety Action Plan and valuation strategy

Improved processes in place which enable agile and productive engagement.
Influence culture of respect with partners

RACS actively provides advice on and influence health policy as it applies to surgery and patient care

OBJECTIVES

To champion professionalism through communicating and advocating with government and relevant stakeholders



KEY ACTIONS

Promote healthcare sustainability initiatives relevant to surgery such as Choosing Wisely programs

Participation in Private Health Insurance initiatives including the development of a Fees/Billing response

Support the Building Respect Improving Patient Safety Action Plan support and Operating With Respect and Foundation

MEASURING SUCCESS

Response received from key government and other stakeholders
Participation across health jurisdictions, statutory agencies, health organisations
Improved culture of surgery and influence through health sector

RACS is committed to maintaining the focus on improving Indigenous health access, outcomes and participation

OBJECTIVES

To implement Indigenous health initiatives with partners including governments, Australian Indigenous Doctors Association, TeORA Māori Medical Practitioners Association.



KEY ACTIONS

Develop new Aboriginal and Torres Strait Islander Reconciliation Action Plan.

Develop new Māori Health Action Plan.

Deliver Indigenous Ear health research business case.

MEASURING SUCCESS

Improved cultural competence
Ear Health research strategy achieves government funding
Increased numbers of Indigenous doctors into training

RACS maintains an informed focus on Rural Health

OBJECTIVES

To increase the level of support for Rural health initiatives from within RACS and across the relevant Federal and State Departments of Health.



KEY ACTIONS

Identify opportunities for improved training pathways for rural health.

Work with current rural surgeons to develop support mechanism for rural based Trainees, Fellows and IMGs.

MEASURING SUCCESS

Increased awareness of the rural community needs for surgery
Pathways for training in rural areas in place

FELLOWSHIP

MEMBERSHIP

GOALS

RACS actively provides support at a local for Fellows, Trainees and IMGs via Australian state and territory, and New Zealand committees and offices

OBJECTIVES

To connect, support and promote initiatives that benefit RACS Fellows

To ensure each local committee has required resources to actively support Fellows, Trainees and IMGs

To increase access for all members and engagement with the RACS strategy

KEY ACTIONS

Improve Fellowship experience.

Deliver support for local initiatives as requested.

Complete the review of the governance structure

Identify needs and deliver effective support of committees/sections.

Connect organisational wide requirements such as CPD/exams/ courses with local Fellows and staff.

Implement and monitor recommendations to changes as approved by the Council

Facilitate increased awareness and access to membership resources including library.

Ensure effective communication with current and future members.

Ensure active participation in the planning and running of the College is optimised for interested Fellows

MEASURING SUCCESS

Fellows feel engaged and benefit from College initiatives
Services are developed to be Fellow centric

Effective engagement by Fellows and Trainees at the local level
Perception of value of membership
Effective promotion of surgery to prevocational stakeholders

Enhanced governance structure with streamlined committee and section structure
Increased Fellow engagement



EDUCATION

STANDARDS AND PROFESSIONALISM

GOALS

RACS is patient-centred

OBJECTIVE

To support the training and sustaining of the surgical workforce to address the needs of the Australian and New Zealand communities.



KEY ACTIONS

Work in partnership with State and National Governments to focus on the needs of rural and regional communities.

Connect education plans and delivery with the Building Respect, Improving Patient Safety (BRIPS) initiatives including the Operating with Respect (OWR) course.

Develop targeted education activities which support the particular learning needs of Trainees and International Medical Graduates (IMG).



MEASURING SUCCESS

An increase in recruitment to rural, regional and private hospital training posts through the Specialist Training Program Project.
Feedback from Fellows, Trainees, IMGs and hospital representatives.
Increased recruitment and retention of trainees and International Medical Graduates (IMGs).

RACS continues to support improvement of surgical education and training

OBJECTIVE

In conjunction with specialty societies, provide exceptional governance across all specialties, leading to exemplary training programs and outcomes for all trainees and IMGs.



KEY ACTIONS

Identify opportunities to work together on projects with shared goals including induction programs for Board members, and support for supervisors.

Strengthen and nurture relationships with key partners including Specialty Training Boards (STBs), The Royal Australasian College of Surgeons Trainees' Association (RACSTA) and Specialty Societies.



MEASURING SUCCESS

Increased alignment and collaboration in key projects.
Continual improvement and alignment of hospital accreditation processes.
Improved reported retention and satisfaction of trainees and IMGs
Improved supervisor satisfaction in surgical programs.

RACS maintains regulatory compliance with accrediting bodies

OBJECTIVE

To ensure all Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) accreditation conditions and recommendations are met.



KEY ACTIONS

Work closely with the accrediting bodies of Australia and New Zealand to comply with all guidelines.

Identify opportunities for alignment and improvement across STB/RACS educational policies and practice in line with AMC/MCNZ requirements.



MEASURING SUCCESS

AMC/MCNZ accreditation conditions and recommendations are met.
Development of a 3-year educational plan.
Feedback from STB, AMC and MCNZ in progress and delivery.

ENDURING VALUE

GOALS

RACS remains a world-leader in surgical education

OBJECTIVES

To actively monitor and evaluate programs to ensure they are evidence-based, align to best practice and meet member needs to deliver the surgical care required.



STRATEGIES

Optimise RACS Research and Evaluation across the College.

Build process and compliance with rigorous planning, monitoring and feedback to inform improvements in education programs.



MEASURING SUCCESS

Development of an overarching evaluation and monitoring framework of all educational activities in line with AMC and MCNZ requirements.

MEMBERSHIP

GOALS

RACS remains a membership organisation for the benefit of patient surgical care

OBJECTIVE

To maximise the quality, sustainability and optimise delivery of all member resource activities.



KEY ACTIONS

Development of an overarching data driven strategy:

- to inform the Educational Portfolio development and delivery
- ensures patient safety through the quality assurance and sustainability of the RACS educational offer.

Use of data to support decisions to effectively meet member needs and exceed expectations.

Utilise the latest intellectual property (IP) legal frameworks to guide the development and dissemination of work.



MEASURING SUCCESS

Delivery and monitoring of education strategy.
Increased engagement and collaboration opportunities for Fellows in education planning and development.
Positive feedback from members about response and service

PARTNERSHIPS

ENDURING VALUE

GOALS

RACS is regarded by its membership, health colleagues and the general public as a trusted voice on all matters associated with surgery and related care.

OBJECTIVES

To develop and deliver a key advocacy platform which is coordinated and activated across the organisation and membership in alignment with the RACS strategy and priorities.

KEY ACTIONS

Build the development of RACS as a trusted voice on surgery and the broader health and wellbeing of our communities.

Develop and disseminate information about agreed areas of advocacy which are aligned with the RACS strategy and support the delivery of the advocacy agenda.

Support the bi-national, national, states, territories and specialty societies with their particular localised areas of advocacy.

Identify areas in which to collaborate with chosen partners to support advocacy priorities.

MEASURING SUCCESS

Clarity of purpose and priorities for advocacy
Delivery of activities against plan.
Approaches to RACS to provide opinion on advocacy priorities.

To build a consistent and valued brand supported by compelling and targeted internal and external communications across a range of traditional and digital channels.

Consistently build the RACS brand across all regions (countries, states and territories) maximising digital and traditional channels

Increase member engagement and connection through targeted and timely communications and publications.

Grow external awareness and reputation through proactive media, digital activities and promotions.

Increase proactive internal communication in partnership with RACS service areas and offices.

Awareness and value of the RACS brand.
Positive traditional and digital media activity.
Membership engagement results.

To increase reach and impact of global health programs which will further deliver positive social value into the Asia Pacific region and recognise our Fellows' contributions.

Build and enhance effective relationships with international organisations and in-country partners.

Plan and deliver surgical care and education in line with in-country and partner priorities, building long-term capacity and workforce.

Advocate for the inclusion of safe and accessible surgical and anaesthesia care in national health plans.

Develop internal processes which ensure compliance and the effective planning, delivery and evaluation all global health programs.

Delivery of programs in line with agreements
In-country stakeholder and donor feedback.
Support of volunteers.

To increase the reach and impact of the Foundation for Surgery which ensures enduring positive value in the community through building the corpus funds and Foundation supporters.

Further develop the direct mail campaigns and commence the planned implementation of the bequest and major donor strategy.

Strengthen the Foundation's capacity to deliver through updated governance and processes.

Develop and extend brand, market and network to promote the Foundation and donations.

Implementation of new approach and system for scholarships.

Engagement levels with current and prospective donors
Financial management and achievement
Delivery of scholarship and grant programs

MEMBERSHIP

GOALS

RACS consistently delivers high quality programs through all conferences and events to further the knowledge of the membership and the broader health community.

OBJECTIVES

To maximise the efficacy of all conferences and events to deliver comprehensive scientific programs aligned with current and future research and education needs of members and further the reputation of RACS.

STRATEGIES

Foster relationships with internal stakeholders, specialty societies and state, territory and country offices to plan and deliver effective conferences and events.

Build relationships with current sponsors and identify opportunities for engaging with new sponsors to broaden the revenue base and secure a sound financial basis for conferences and events.

Deliver all conferences and events for 2019 against plan and budget with increased participation and satisfaction.

Identify new technologies which will enhance the participant's experience from registration, attendance and post-event.

MEASURING SUCCESS

Clarity of purpose and priorities for advocacy
Delivery of activities against plan.
The number and relevance of approaches to RACS to provide opinion on advocacy priorities.

OPERATIONS

ENDURING VALUE

GOALS

RACS is financially sustainable and delivers financial value across the membership

OBJECTIVE

To pursue revenue growth opportunities, and employ financial resources in a manner that demonstrates value across the membership.



KEY ACTIONS

A RACS Growth Strategy that is aligned to the Strategic Objectives and enables growth opportunities to be purposed.

Financial resources are prioritised and employed in a manner that funds service improvement initiatives.

MEASURING SUCCESS



Growth in revenue.
Funding for service improvements.
Financial budget and tracking.

RACS teams are highly capable and responsive in delivering value across the membership.

OBJECTIVE

To build an organisational structure and culture that is committed to RACS values and can deliver new and improved services across the membership



KEY ACTIONS

Staff engagement is measured and opportunities to align the culture with RACS values are pursued

Cultural awareness initiatives are actively pursued throughout RACS.

Contemporary employment practices in place that build staff engagement and enable teams to continuously improve service delivery across the membership.

MEASURING SUCCESS



Staff engagement is measured and monitored.
Cultural activities pursued for all staff.
Employment practices continuously improved.

STANDARDS AND PROFESSIONALISM

GOALS

RACS continues to build awareness and support those experiencing discrimination, bullying and sexual harassment.

OBJECTIVES

To support Fellows, Trainees and IMGs experiencing discrimination, bullying and sexual harassment in their workplaces.



STRATEGIES

Processes are implemented that enhance the confidence of Fellows, Trainees and IMGs in dealing with discrimination, bullying and sexual harassment in their workplaces.

Work with hospitals and our Fellows, Trainees and IMGs in creating safe training environments.

MEASURING SUCCESS



Building Respect and Improving Patient Safety impact is assessed.
Evaluation of RACS complaints processes.
Improvements in complaints processes.

MEMBERSHIP

GOALS

RACS technology and digital applications deliver services in a surgeon-centric manner

OBJECTIVE

To continually improve and invest in digital solutions that deliver an improved service experience across the membership.



KEY ACTIONS

Development of a RACS Technology Roadmap that enables the delivery of new digital services in a surgeon-centric manner.

User-centred design principles are employed during the development and delivery of RACS digital services.

Surgeon interactions across RACS services drive experience improvements.

MEASURING SUCCESS



A RACS Technology Roadmap that delivers digital services in surgeon-centric manner.
A CRM that captures, drives and anticipates surgeon needs from RACS.
A service delivery model focused on services experience across the membership.



Appendix 2 Policy: Challenging a RACS decision

POLICY		ROYAL AUSTRALASIAN COLLEGE OF SURGEONS	
Portfolio:	Education	Ref. No.	-EDU-xxx
Department:	Education		
Title:	Challenging a RACS Decision		

Approved for internal circulation. Not yet available for publication.

1. PURPOSE AND SCOPE

This Policy sets out the formal process for challenging a decision, being via the process of Reconsideration, Review and Appeal, by any person, organisation, or body corporate (an Applicant) affected by a decision of the Royal Australasian College of Surgeons (RACS).

The three-step process involved in formally challenging a decision is intended to minimise the need for Applicants to undertake an Appeal to resolve their issue. It is expected that many issues will reach a satisfactory outcome in the Reconsideration and Review steps.

The purpose of this Policy is to set out the three sequential steps that may be taken by an applicant aggrieved by a decision, those being to apply for:

1.1. Reconsideration.

This step provides the applicant with the opportunity to submit additional information to the original decision maker. This additional information must have been available and known (or should have been known) at the time that the original decision was made.

1.2. Review.

This step provides the applicant with the opportunity to provide the reasons (to an independent review panel) that they believe there has been a procedural error in making that decision.

1.3. An appeal.

This step provides the applicant (known as the appellant) with the opportunity to present their case for consideration by an independent appeals committee "Insert detail"

2. GENERAL PRINCIPLES

2.1. Fees

2.1.1. No fee is required for Reconsideration or Review.

2.1.2. An Applicant will be required to pay a fee for an Appeal:

- a. The relevant fee is available on the RACS website
- b. This fee must be paid at the time a request for an Appeal is lodged
- c. If the Appeals Committee upholds the appeal in its entirety, 50% of the fee will be refunded.

2.2. Appointment and Delegation

The Reconsideration, Review and Appeal Officer ("RRA Officer") shall be appointed by the CEO. The RRA Officer may delegate their powers and duties in respect of this Policy and any procedures made under it.

2.3. Matter Progression

2.3.1. Generally, Applicants will have their matter considered in accordance with the three-step mechanism in the stated sequence, that is, they will commence at the Reconsideration step before continuing to a Review and then Appeal.

2.3.2. The Reconsideration and / or Review steps may be bypassed if approved by RACS.

Document Authoriser:	Executive General Manager, Education	Original Issue:	"Month YYYY"
Document Owner	RRA Officer	Version:	No.
		Approval Date:	"Month YYYY"
Page 1 of 8		Review Date:	"Month YYYY"

Portfolio:	Education	Ref. No.	EDA-EDU-xxx
Department:	Education		
Title:	Challenging a RACS Decision		

2.4. Exemption

Applications submitted under this Policy will not be accepted where the Applicant is seeking an exemption from any approved policy or regulation.

2.5. Applicant's request for documents

2.5.1. An Applicant may, prior to requesting a Reconsideration or Review, request from the original decision maker copies of documents on which the decision was based. The original decision maker must respond to this request within 14 days of receipt of a written request, and in their response shall have regard to privilege, privacy and confidentiality obligations.

2.5.2. Failure to receive a response from the original decision maker to a request for documents shall not be accepted as a reason for failure to lodge an Application on time. The Applicant must meet all timing requirements in this Policy, noting if the documents have not been received from the original decision maker. -

2.6. Reporting

RACS will publish annually an Activities report including the number of Applicants using this mechanism and the relevant outcomes.

3. DECISIONS ABLE TO BE RECONSIDERED, REVIEWED OR APPEALED

An Applicant may apply for a Reconsideration, Review or Appeal of the following decisions:

- a. Selection, training, or admission to Fellowship
- b. Specialist assessment and clinical assessment of International Medical Graduates (IMGs)
- c. The accreditation of training posts or IMG clinical assessment posts
- d. Accreditation of Post Fellowship Education and Training programs and Accreditation of Courses
- e. Decisions of the Professional Conduct Committee (Appeal only)
- f. Such other decisions of RACS, its Boards or Committees (including conjoint Committees), or its agents as the CEO may determine from time to time

4. STEP ONE – RECONSIDERATION

4.1. Initiation of Reconsideration

4.1.1. Any person who is directly affected by and is dissatisfied with a decision of RACS may apply to have the original decision maker reconsider its decision.

4.1.2. The application for Reconsideration must include any additional material or documentation not previously considered (if applicable), but only where such material was available and known (or should have been known) to the original decision maker at the time the decision was made.

4.1.3. Where RACS specifies a form for use for this purpose, this form must be used.

4.1.4. The Applicant is entitled to provide written submissions at the time of application (unless requested by the original decision maker), which they consider may assist in this process.

Document Authoriser:	Executive General Manager, Education	Original Issue:	"Month YYYY"
Document Owner	RRA Officer	Version:	No.
		Approval Date:	"Month YYYY"
		Review Date:	"Month YYYY"

Portfolio:	Education	Ref. No.	EDA-EDU-xxx
Department:	Education		
Title:	Challenging a RACS Decision		

- 4.1.5. If the RRA Officer determines in their absolute discretion that there are insufficient grounds for an application for Reconsideration or that the information provided by the Applicant falls outside the requirements, grounds and terms contained in this Policy, RACS shall inform the applicant and will not be obliged to consider the application or any further information provided, unless the further information brings the matter within the jurisdiction of this Policy.

4.2. Timeframe

- 4.2.1. An application to use this process must be received by RACS within twenty-eight (28) days of the date of the original decision unless it is a decision relating to selection to the surgical education and training program, which must be received by RACS within seven (7) days.
- 4.2.2. If the decision is provided in writing, the date of the written notification shall be taken to be the date of the decision for this purpose. Failure to receive documents requested under clause 2.5.1 shall be noted by the Applicant on their application and shall not be accepted as a reason for late lodgement of an application. The Applicant must comply with 2.5.2.
- 4.2.3. RACS will acknowledge receipt of the application within seven (7) days of receipt.

4.3. Conduct of Reconsideration

The original decision maker shall reconsider the decision together with all original material previously before the original decision maker, any additional materials provided by the Applicant and in their submissions (if any).

4.4. Outcome of Reconsideration

- 4.4.1. RACS aims to complete the Reconsideration process within twenty-eight (28) days of receipt of the complete application received pursuant to this Policy. Following completion of the Reconsideration, RACS will notify the Applicant in writing of the decision. In the event the original decision is upheld, the communication to the Applicant shall contain:
- A summary of the reasons for the decision being upheld; and
 - Information on the further options open to the Applicant.

5. STEP TWO – REVIEW

5.1. Initiation of Review

- 5.1.1. Any person who remains dissatisfied with the original decision or the Reconsideration decision and believes there has been a procedural error in making that decision, may apply to have that decision reviewed by a Review Panel.
- 5.1.2. The Applicant is entitled to provide written submissions at the time of application, which they consider may assist in this process. Where RACS specifies a form for use for this purpose, this form must be used.

5.2. Timeframe

- 5.2.1. The application for Review of a decision must be received by RACS within fourteen (14) days of the date of the written notification of the reconsidered decision.

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5.2.2. RACS will acknowledge receipt of the Applicant's application within seven (7) days of receipt.

5.3. Conduct of Review

5.3.1. RACS shall convene a Review Panel, which shall comprise of three people approved by the CEO or their delegate for this purpose. The Review Panel shall not include a member who participated in the original decision or the Reconsideration decision or who otherwise has, or may be perceived to have, a conflict of interest. The Review Panel may include a specialty representative if appropriate.

5.3.2. The Review Panel shall consider and conduct the Review on the basis of:

- all the material and documentation considered by the original decision maker when making the original decision or reconsidering it under this Policy;
- any submissions made by the Applicant under 5.1.2;
- whether the principles of procedural fairness and natural justice were followed when the original decision was made and when it was reconsidered; and
- any RACS regulations, policies and procedures relevant to the decision.

5.3.3. The Applicant does not have the right to attend any meetings of the Review Panel or to make any oral submissions to it, either personally or through any other party.

5.3.4. The Review Panel may inform itself as it sees fit subject to the rules of procedural fairness.

5.4. Outcome of Review

5.4.1. The Review Panel may only make one of the following decisions:

- affirm the original decision or Reconsideration decision,
- set aside the original decision or Reconsideration decision and require that an alternative process be undertaken to arrive at a decision, or
- set aside the original decision or Reconsideration decision and remit the matter back to the original decision maker with directions.

5.4.2. The decision of the Review Panel is binding on the original decision maker who must comply with any directions.

5.4.3. The Review Panel may not make any decision other than those which are open to be made by an Appeals Committee under this Policy.

5.4.4. RACS aims to complete the Review process within twenty-eight (28) days of receipt of the complete Review application received pursuant to this Policy. Following completion of the Review, RACS will notify the Applicant in writing of the decision and, if relevant, will advise the Applicant of their right to appeal the decision.

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6. STEP THREE - APPEAL

6.1. Initiation of Appeal

- 6.1.1. Within fourteen (14) days of the Applicant being notified in writing of the outcome of the Review under this Policy, the Applicant (known as Appellant) may submit an application for an Appeal.
- 6.1.2. To constitute a valid application for Appeal, the application must contain all of:
- The prescribed appeal fee, and
 - Details of the specific decision that is being contested, and
 - The Grounds of Appeal, based on the allowable Grounds of Appeal as described in clause 6.2, and
 - A summary of the facts or other means by which the matter falls within the stated ground(s), and
 - A statement that evidence exists that supports the Grounds of Appeal.

6.2. Grounds of Appeal

- 6.2.1. The grounds under which an application for an Appeal can be made are:
- That an error in law or in due process occurred in the formulation of the original decision.
 - That relevant and significant information, which should have been known to the decision maker, was not considered or not properly considered in the making of the original decision.
 - That the original decision was not one which a rational decision maker could make.
 - That irrelevant information was considered in the making of the original decision.
 - That the original decision was made for an improper purpose.
 - Any application which does not meet these requirements may be rejected by RACS.

6.3. Acceptance of Appeal Request

- 6.3.1. RACS shall, within fourteen (14) days of receipt of a properly initiated and complete application for Appeal in accordance with section 6.1 of this Policy, advise the Appellant and the original decision maker that an Appeal will be heard. This advice will include:
- The date, time and place of the Appeal hearing;
 - The right of and expectation that the Appellant will appear before the Appeals Committee in person;
 - The right of the Appellant to be accompanied by a legal practitioner to assist them in the manner set out in clause 6.7.4;
 - The right of the Appellant to have a support person present who may attend regardless of whether the Appellant has a legal advisor.

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e. Timeframes for production and exchange of documents which shall include all relevant documentation held by RACS, subject to obligations of privilege, privacy or confidentiality which may apply

6.3.2. Unless otherwise advised in writing by RACS, the decision under appeal remains in effect until the appeal is heard and determined.

6.4. Appeals Committee Composition

6.4.1. An Appeals Committee will be comprised of the following members:

- a. three persons who are not Fellows of RACS, one of whom shall chair the committee (Chair);
- b. the Vice President of RACS or a delegate who is a Fellow of RACS; and
- c. one Fellow of RACS.

6.4.2. Members of the Appeals Committee must not have been involved in the decision to which the appeal relates or have any conflict of interest in the matter.

6.4.3. Council has delegated the appointment of persons to the pool of Appeals Committee members, including the Chair, to the CEO.

6.4.4. A quorum for meetings of the Appeals Committee will be a Chair and three other members. All members of the Appeals Committee shall be entitled to vote on decisions and the outcome of the appeal shall be decided on the basis of a majority vote if consensus cannot be achieved. In the event of a tied vote the Chair will have a casting vote.

6.5. Persons at Appeals Committee meeting

6.5.1. The CEO, or their delegate, will appoint a person to be the legal advisor to the Appeals Committee.

6.5.2. The original decision maker may also request the Manager of the RACS legal department to appoint a legal advisor.

6.5.3. The RRA Officer may request or permit other persons to attend meetings of the Appeals Committee.

6.5.4. Any legal advisor appointed under 6.3.1(c), 6.5.1 or 6.5.2 may not act as advocate of the relevant party and may only address the Committee, if requested, on legal matters and is otherwise there to provide legal advice to the relevant party directly in a manner which does not disrupt the proceedings.

6.6. Submissions to the Appeals Committee

6.6.1. In any Appeal, the Appellant will carry the burden of proof to establish the decision should be overturned, including the specific grounds on which this is based.

6.6.2. The Appellant will provide to RACS written submissions and copies of any documents and records upon which they wish to rely within the time specified in any communication from RACS. The Appellant shall have no less than twenty-one (21) days to undertake this. This written submission must be within the context of the original submission for an appeal, and cannot introduce new grounds of appeal. A copy of the submission will be made available to the original decision maker.

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- 6.6.3. The original decision maker will provide a written submission in response to the Appellant's submissions and grounds of Appeal within the time specified in any communication from RACS. The original decision maker shall have no less than twenty-one (21) days to undertake this. The decision maker's submissions will contain any additional documents relevant to the decision or their submissions.
- 6.6.4. The Appellant may lodge a rebuttal within the time specified by the RRA Officer which cannot be less than fourteen (14) days before the scheduled appeal date. No further material will be accepted after this time.
- 6.6.5. All submissions and rebuttals lodged by both parties in accordance with this Policy will be provided to the other party and to the Appeals Committee.

6.7. Conduct of Meetings of the Appeals Committee

- 6.7.1. The Appeals Committee must act according to the rules of procedural fairness. The Appeals Committee is not bound by the rules of evidence and, subject to the rules of procedural fairness, may inform itself on any matter and in such manner as it thinks fit.
- 6.7.2. The Appeals Committee shall be entitled to consider all relevant information which it thinks fit and may invite any person to appear before it, or to provide information. Witnesses are not compellable.
- 6.7.3. An Appellant is expected to appear before the Appeals Committee at their own cost and to advocate the merits of their appeal further to their written submissions. An Appellant may be excused from this requirement where attendance would cause undue hardship to the Appellant or for another reason acceptable to the Committee. Where an Appellant is excused from attending in person, their legal advisor may exercise all the rights and shall bear all of the obligations of the Appellant at the hearing.
- 6.7.4. The Appellant has the right to be advised by a legal representative and/or a support person. Legal advisors may not act as advocates for the Appellant but may be invited to address the Appeals Committee regarding a particular legal issue that the Appeals Committee believes cannot adequately be addressed by the Appellant.
- 6.7.5. A representative of the original decision maker is expected to attend and address the Appeals Committee on matters relevant to the appeal and will be given equal opportunity to provide submissions to the Appeals Committee. Any legal advisor appointed to advise the original decision maker may not act as an advocate but may be invited to address the Appeals Committee regarding any particular legal issue that the Appeals Committee believes cannot adequately be addressed by the original decision maker.

6.8. Outcome of Appeal

- 6.8.1. An Appeals Committee may, upon considering all submissions, determine:
- To confirm the decision under appeal; or
 - set aside the original decision and require that an alternative process be undertaken to arrive at a decision, or

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- c. To revoke the decision under appeal and refer the decision back to a relevant decision maker for further consideration in accordance with the Appeals Committee's directions
- 6.8.2. The Appeals Committee cannot make a decision that the original RACS decision maker could not have made and cannot make an order in relation to costs. In addition, the Appeals Committee may not:
 - a. Elevate an Appellant above others in a competitive assessment for selection to the SET program without reference to the scoring process;
 - b. Recommend a pathway to Fellowship for an IMG without reference to a new IMG Assessment Panel;
 - c. Revoke the clinical or examination assessment of a trainee and replace the assessment with an assessment of its own, or
 - d. Award a Fellowship to any Appellant.
- 6.8.3. The decision of the Appeals Committee is binding on the original decision maker who must comply with any directions.
- 6.9. Notification of Outcome**
 - 6.9.1. The Appeals Committee will issue a written decision, with reasons for the decision, as soon as practicable, but in any event no later than twenty eight (28) days from the date of the appeal hearing.
 - 6.9.2. The Appeals Committee's decision takes effect from the date of the written decision which shall be forwarded on the same date to the Appellant and the relevant decision maker.

7. COMPLIANCE WITH LAWS AND REGULATIONS

Nothing in this Policy authorises a Review Panel or Appeals Committee to direct that an act be done or a process be undertaken by any decision maker which is unlawful or outside the terms or authority of the Regulations or Policies of RACS as they existed at the time of the original decision, save that a direction may be given to use a decision making process which did not exist at the time of the original decision where it would not demonstrably disadvantage the Applicant or Appellant.

8. ASSOCIATED DOCUMENTS

Approver Education Board
Authoriser Council

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Executive Summary extract:

**Royal Australasian
College of Surgeons**

**Building Respect, Improving
Patient Safety Action Plan**

**Phase 1 Evaluation
Final Report**

June 2019



www.thethreadconsulting.com.au

Executive Summary

Background

Action Plan history

In 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group (EAG) to investigate the extent of discrimination, bullying and sexual harassment within the surgical profession. EAG research revealed widespread discrimination, bullying and sexual harassment in the practice of surgery. This raised serious concerns for the wellbeing of individual surgeons and surgical trainees, of surgical teams and especially for the quality of care and safety of patients.

RACS responded to these issues by developing an Action Plan, *Building Respect, Improving Patient Safety* (Action Plan) (Attachment 1), which outlines how RACS intends to counter and drive out unacceptable behaviours from surgical practice and surgical training.

Goals

The Action Plan describes the actions needed to address each of the EAG recommendations. It contains eight goals, arranged under the three key action areas identified by the EAG. These goals are supported by a comprehensive workplan, which has been prioritised and gradually implemented.

Context

Implementation of the Building Respect Action Plan is a highly complex challenge, involving negotiation of multiple partnerships and priorities across health jurisdictions in two countries. It has been accomplished in an environment with many contextual influences, including rapidly changing community attitudes and expectations regarding respectful behaviours, as exemplified in the #Metoo movement. Achieving the goals of the Action Plan will require significant cultural change, and some resistance is to be expected, with some groups taking longer to change their attitudes and behaviours than others.

The Phase 1 evaluation

This was the first evaluation of the Building Respect Action Plan. As such, it was primarily focussed on further development and implementation of the program, whilst also looking for very early indicators of progress towards outcomes. The scope for this evaluation covered:

- Measure whether program implementation, governance and oversight are proceeding as intended.
- Measure whether early outcomes (delivery of pathways for identifying and addressing concerns about behaviour; program reach; target audience perceptions of the Action Plan) are being achieved as intended.
- Identify program strengths, what is working well, barriers to progress.

- Make recommendations on areas for program adjustment or improvement, based on findings.

The evaluation was conducted by collecting evidence against two Key Evaluation Questions (KEQ) focussed on Action Plan implementation and governance. A number of evidence sources were used, including documents, reports, presentations, a survey of College members, and in-depth interviews with selected Fellows, Trainees and International Medical Graduates (IMGs) to explore emerging issues. The findings and draft recommendations were validated with the Project Reference Group (PRG) before being finalised in this report.

Findings

The Key Evaluation Questions (KEQ) are shown below, together with their related findings.

KEQ 1: Has the Action Plan been implemented as intended to date?

Key points

- A significant amount of work has been delivered.
- Almost all of the program elements have been delivered according to plan.
- Visible commitment by College and Council is a strength.
- Building Respect elements are reaching target audiences.
- Deep permeation of the key messages.
- Some pockets of resistance to cultural change remain.
- RACS' complaints process, like other complaints processes, is not perceived as safe.
- Trainees do not appear to be very engaged with the College.
- Very strong support for the Action Plan amongst RACS membership.
- Challenge for RACS is that respectful behaviour is a whole of healthcare issue.
- Implementation of the Action Plan is in line with societal change.

Summary

The College's swift action in response to the recommendations of the EAG, its allocation of significant resources to the Building Respect Action Plan, and its appointment of a senior position to lead the implementation have been seen by the majority of interviewees and survey respondents as a strong commitment to the Action Plan. Almost all of the Action Plan has been delivered as planned, a significant achievement, given the size of the task. Overall the Action Plan has been positively received and is very strongly supported by Fellows, Trainees and IMGs.

The College is now seen to be in step with public opinion and broader societal shifts. More than this, the College is now seen as leading the way as an institution that has acknowledged these problems and made a serious commitment to addressing them.

The right audiences are receiving Action Plan communications via multiple sources, contributing to the high level of awareness of the key messages and the majority of actions that the College has taken. Survey respondents declared that they had a strong understanding of the issue around respectful behaviours and the need to take action. The visibility of the issue has brought it out in the open, with many people describing a new and growing dialogue within the workplace, with the reach of awareness extending beyond surgery to encompass other medical disciplines.

The survey highlighted a remarkably high level of support for the College's commitment to addressing discrimination, bullying and sexual harassment in surgery, with 95% of 1346 Fellows, 96% of 244 Trainees and 93% of 62 IMGs supporting the College's commitment. Early outcomes such as perceived cultural change in the workplace and representation of women in surgical training, are making good progress. RACS is leading the way in developing a model for introduction of respectful behaviours, with other Colleges and organisations turning to the College for policy advice and education programs.

A significant and visible element of the Action Plan was the education program, including the mandatory online e-module, which has now been completed by over 98% of Fellows, Trainees and IMGs; the face to face Operating With Respect course (OWR) mandated for surgical supervisors and RACS major Committee Members; and the Foundation Skills for Surgical Educators course (FSSE), with only 3% of the mandated cohort being followed up as this report was being prepared.

Despite this success, there remains a significant cohort of members that are resistant to change and unable to adjust their communication style. Interviewees reported scepticism amongst some of their colleagues regarding the Action Plan and pockets of resistance from others who describe the Action Plan as "*political correctness gone mad.*" An incidental finding was that Trainees do not seem to be well engaged with the College, possibly through time limitations or fear of negative consequences for those highlighting unacceptable behaviours.

The major area for improvement is the College's complaints process, which, despite an increase in the number of complaints relating to respectful behaviours, is, like other complaints processes, not perceived as safe by more than half of Trainees.

Strengths

Implementation of the Action Plan has been successful and well delivered. One of the key strengths of the Action Plan has been highlighting the evidence linking behaviour to patient safety in its messaging and call to action. This is evidenced by the strong awareness of this message, shown in the survey responses. Another strength of the Action Plan has been the communications function. There has been strong

branding, development of a professional logo and strapline and very effective messaging targeted at the key audiences.

The huge and visible level of commitment and enthusiasm from College and Council have been observed by interviewees and survey respondents alike. This commitment has also been displayed in the prioritisation of resources to the Action Plan implementation, another strength of the College's approach to addressing this issue.

Opportunities for improvement

The RACS complaints process, like other complaints processes, is not perceived as safe by more than half of Trainees, and a substantial proportion of IMGs and females. The major reason for this is a lack of confidence that it will lead to positive outcomes, and fear that it could result in severe negative career consequences. The College has already recognised that the complaints system needs improvement, and it is currently being revised.

Despite the strong awareness of the key Action Plan messages, there is still a range of attitudes and entrenched beliefs about what is acceptable behaviour in the surgical workplace. Although it is expected that change will happen at a different pace for different cohorts, and there are likely to be people for whom the changes will take longer, there is an opportunity to consider ways to influence these "pockets of resistance" or whether the cultural change should be allowed to more gradually permeate.

Trainees are not as engaged with the College as other groups. Trainees and IMGs are not as aware of the key messages as Fellows. This could become an issue for future Fellows who may not have absorbed the messages early in their careers. Therefore, there is an opportunity to target messages specifically to these cohorts.

KEQ 2: Is program governance and oversight effectively supporting delivery of the Action Plan?

Key points

- The Action Plan has been resource-intensive.
- Action Plan outputs and activities are being closely monitored.
- Program outcomes are being evaluated as they develop.
- Emerging evidence and lessons learned inform practice.
- RACS is addressing identified strategic challenges for further implementation.
- RACS reports transparently to stakeholders about progress towards building a culture of respect.

Summary

The Building Respect Action Plan is extensively and effectively monitored. At this early stage of program implementation, the focus is on Action Plan outputs and activities,

with regular reporting through senior management and the CEO, to Council, Board of Council and the Building Respect Implementation Group. External evaluation and review have been built in to provide outcomes reporting at the appropriate stage of program development and to inform the continuous improvement approach. There is evidence to indicate that adjustments are being made to the Action Plan as new evidence or practical barriers emerge. Importantly, RACS management and Council have identified the key strategic challenges for further implementation and already have plans to address them.

Strengths

Dedicated senior position

One of the major strengths of the Action Plan has been the establishment of a dedicated senior position to drive program implementation. This has achieved a focal point for advocacy, coordination and progress monitoring, which has contributed to the strong achievements to date.

Culture of continuous improvement

Another strength is the culture of continuous improvement, evident through the close monitoring of actions and outputs against plans, and the openness to receive recommendations from external reviewers and examine the evidence for emerging trends and ideas. This underpins the Action Plan's adaptability, agility and responsiveness.

Transparent reporting

Transparency is also a key strength of the Action Plan. There has been extensive reporting both within and externally to the College about progress towards a culture of respect and this has strengthened the College's position as a leader in this significant undertaking, and validated the importance of this work to its members.

Opportunities for improvement

Addressing the cost of the Action Plan

Action Plan implementation has been resource-intensive, particularly the mandatory education, which has been funded by diverting resources from other priorities. There is no comprehensive cost recovery plan which could support sustainability of the Action Plan in the longer term.

Incorporating Building Respect principles into Business as Usual

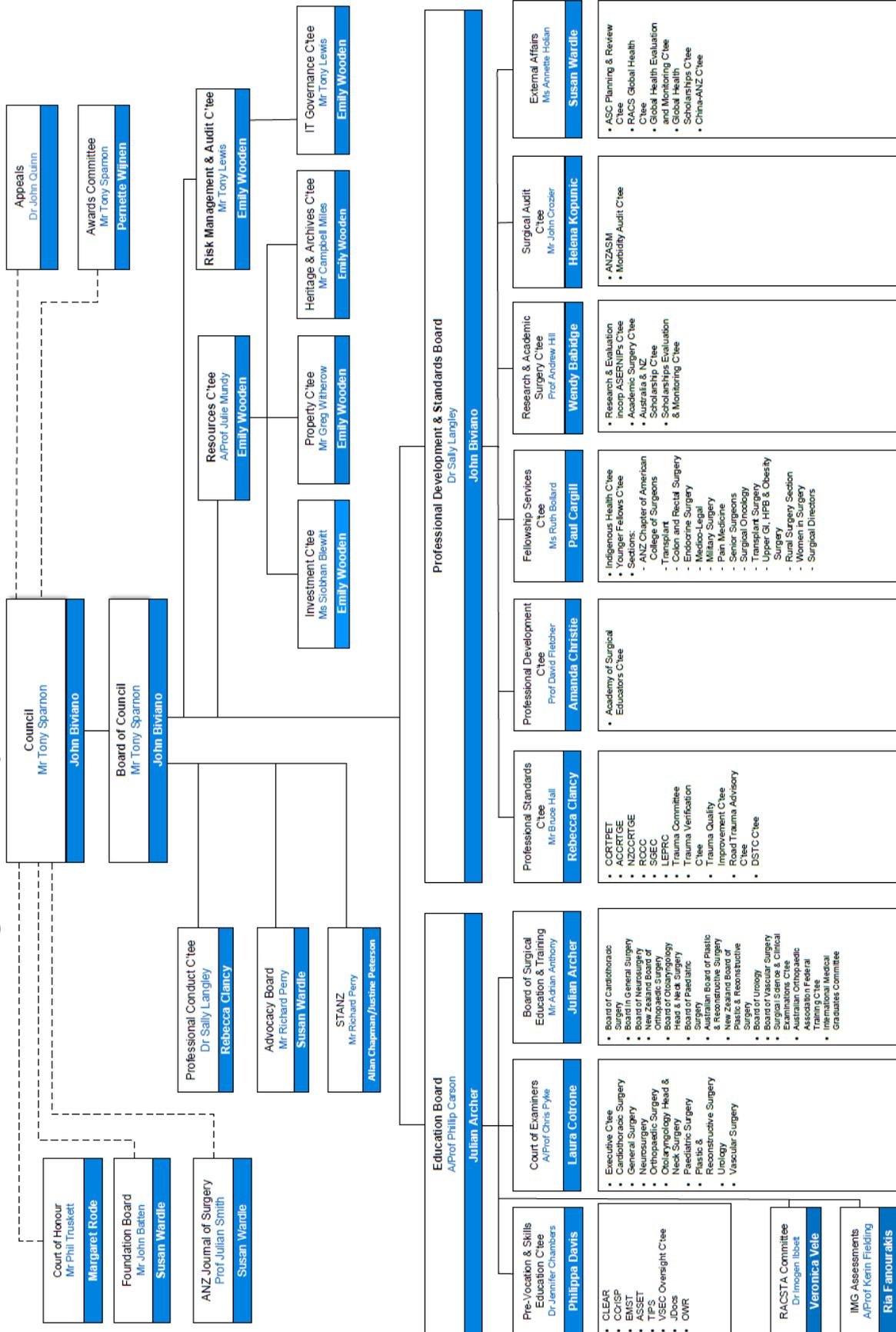
Although the Action Plan is nominally mentioned in the current RACS Strategic Plan, the Building Respect principles are not incorporated into all the elements of the Plan.

Inform Council about the introduction of outcome reporting

Councillors spoke of their need to see outcomes reporting against the Action Plan, however, it is very early in the program implementation to be able to measure many of the outcomes with any certainty. It is important to inform the Council about the planned schedule for outcome reporting over the remaining two phases of the evaluation.

Appendix 4 RACS governance management map

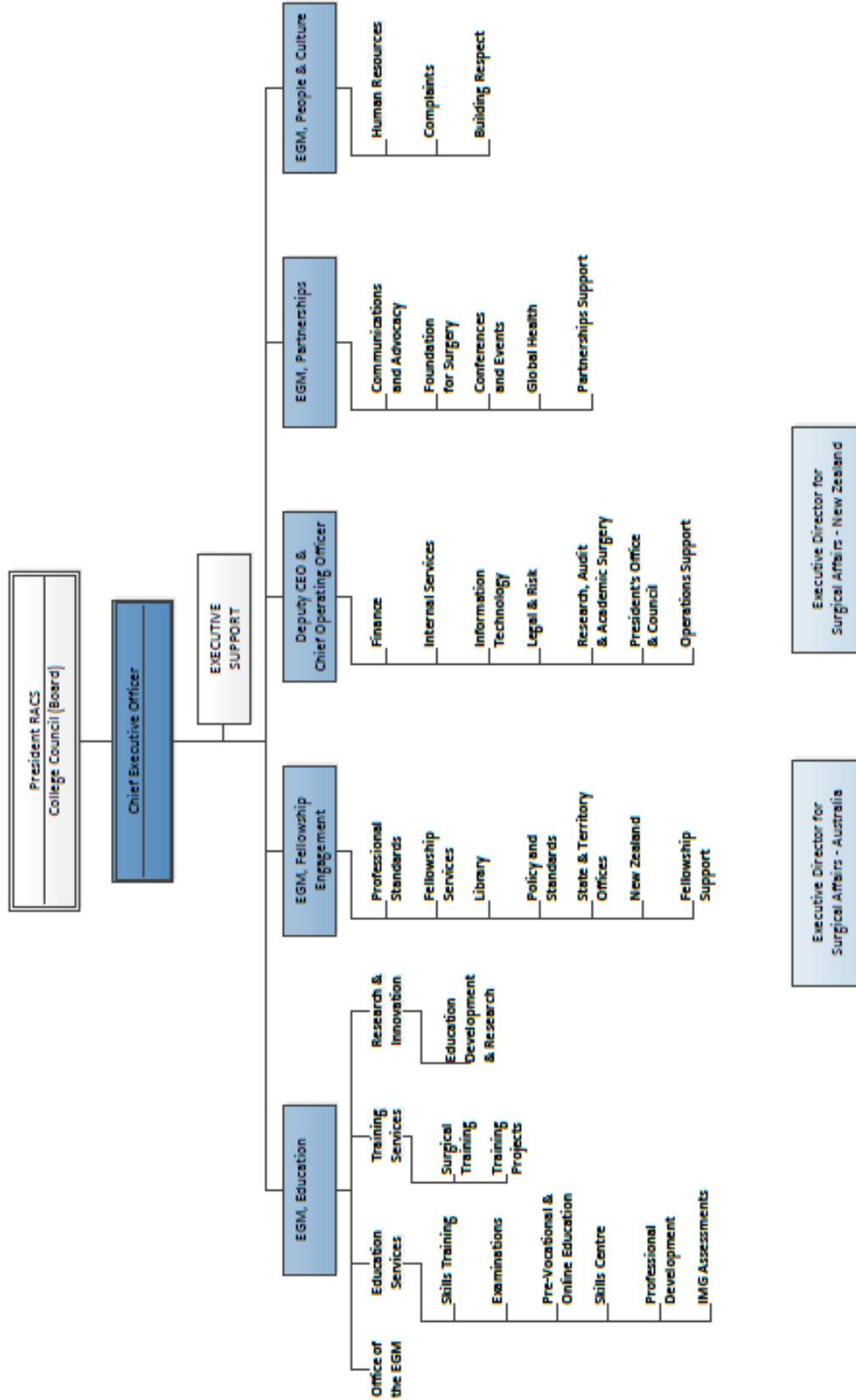
RACS Governance Management Map



CEO Office 5 August 2019
V5



ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS



Appendix 6 RACS response to *Review of Assessments Report* (Wannan, 2016)**Addressing AMC accreditation condition 15****AMC Condition 15**

Respond to the 2016 Review of Assessments Report by Cassandra Wannan by noting whether recommendations have already been implemented, require implementation or are rejected, including a rationale for the latter. (Standards 5.2 and 5.4)

RACS response to Condition 15

In 2018, RACS' Education Board, and RACS' Court of Examiners and Surgical Science and Clinical Examinations Committee considered the *Review of Assessments Report* (Wannan, 2016) and recommendations regarding examinations. In addition, RACS' specialty training boards (STBs) considered Wannan's recommendations for work-based assessments as well as those pertaining to examinations. None of the recommendations was rejected outright.

Responses to recommendations on work-based assessments

RACS specialties are at different stages of the curriculum review, development and implementation cycle. As specialties develop new curricula, they review workplace-based assessment (WBA) tools and processes to improve clinical relevance and blueprint to the curriculum.

Development of assessment practices for inclusion in the generic, professional skills curriculum (planned to commence in the second half of 2019) will explicitly incorporate recommendations from the Wannan report. See Table 15 for a summary of RACS' responses to Wannan's recommendations pertaining to work-based assessments.

Table 15 RACS response to Wannan Report recommendations – Work-based assessments (WBAs)

WBA recommendations	RACS initiatives in response	RACS planned initiatives	Recommendation rejected with explanation
<p>1. Review WBA tools and their implementation</p>	<p>Review of WBA tools, including frequency and diversity of methods is a key component of RACS specialty curricula review and development. RACS specialties have introduced PBAs, EPAs, MSF into new curricula.</p> <p>The JDocs framework introduced assessments of key clinical tasks, following a WBA review.</p>	<p>Development of the professional skills curriculum in 2019 will include review of WBA good practice; evidence-based WBA methods will be included in this curriculum.</p>	

WBA recommendations	RACS initiatives in response	RACS planned initiatives	Recommendation rejected with explanation
2. Improve clinical relevance of WBAs	RACS specialty curricula review and development includes staging of assessments through SET to better track trainee progress and increasing complexity of assessment criteria.		
3. Blueprint WBAs onto the curriculum	See responses to 1. And 2. above. Revised specialty curricula include staged WBAs from early to late SET and identification of relevant, competency-based assessments throughout training.	The professional skills curriculum will identify stages and relevance of WBAs.	
4. Use Entrustability Scales to improve reliability of WBA ratings	RACS general surgery, orthopaedic surgery, P&RS Au, and urology, have developed and introduced EPAs into their own specialty curricula.	RACS is considering introducing EPAs into some aspects of the professional skills curriculum.	While EPAs are being introduced into RACS specialty training, RACS rejects the idea of using Entrustability scales for existing WBAs (such as DOPS, MiniCEX, ETA). WBAs assess the small components that make up CBME programs. EPAs are a different methodological approach to curriculum delivery and assessment.

WBA recommendations	RACS initiatives in response	RACS planned initiatives	Recommendation rejected with explanation
5. Train raters	RACS specialties in cardiothoracic surgery, OHNS, and Vascular surgery conducted interviewer training workshops in 2019. AOA FTC conducts assessor training.	Resources are being developed in 2019 and 2020 to support supervisors. These will include training in assessment and feedback. As new specialty curricula are introduced, supervisors are trained in use of new assessment tools and processes.	
6. Use multiple assessments and assessors	All RACS specialties use multiple assessments and assessors.	Additional review of assessment protocols would enhance understanding of WBA implementation. Such a review is not yet planned.	
7. Provide meaningful, constructive feedback	AOA FTC and P&RS Au have implemented this. RACS incorporates training in feedback in PD courses including FSSE, Advanced Feedback, and OWR.	Resources are being developed in 2019 and 2020 to support supervisors. These will include training in assessment and feedback.	

WBA recommendations	RACS initiatives in response	RACS planned initiatives	Recommendation rejected with explanation
<p>8. Introduce multi-source feedback (MSF)</p>	<p>To date, RACS STBs in cardiothoracic surgery, general surgery Au, paediatric surgery and urology are using MSF, for trainees in difficulty.</p> <p>Most MSF/360 evaluations are currently only used for trainees in difficulty or for SET1 trainees.</p> <p>RACS is also exploring the use of multi-source Feedback (MSF) more widely across all of our surgical programs in the evaluation of trainees which will involve surgical team members, other health professionals and administrators.</p>	<p>The RACS MSF model is under review, including alignment with best practice and developing a model of facilitated feedback across trainee and post-Fellowship.</p> <p>It is likely that RACS will introduce regular MSF for trainees as part of a framework for monitoring and evaluation, which will include all training and educational processes.</p>	
<p>9. Introduce assessment portfolios</p>	<p>Assessment portfolios have been implemented by:</p> <ul style="list-style-type: none"> • JDocs • AOA FTC 	<p>RACS is supportive of assessment portfolios as ongoing records of individuals' progress from JDocs to independent practice and CPD. RACS' 'Project Sonic', aims to facilitate this approach to streamline support for our members.</p>	

Responses to recommendations on examinations

In 2018 and 2019, reviews of examiner training and of feedback provided to candidates were undertaken, resulting in a new examiner training course being piloted and feedback templates being introduced. RACS ran workshops, at which panels of specialty SMEs were presented with three evidence-based standard-setting methods. All specialties that conduct specialty-specific exams agreed to implement one of the recommended options.

See Table 16 for a summary of RACS' responses to Wannan's recommendations pertaining to examinations.

Table 16 RACS response to Wannan Report recommendations – Examinations

Examinations recommendations	RACS initiatives in response	RACS planned initiatives	Recommendation rejected with explanation
1. Blueprinting to be used in designing all exams to ensure that the curriculum is being adequately assessed.	Implemented for all RACS examinations, including: <ul style="list-style-type: none"> • GSSE • CE • Specialty-specific exams in all RACS specialties that conduct specialty exams. • Fellowship exams 	Review of blueprinting methods will coincide with implementation of a new question management system in 2020.	
2. Steps should be taken to improve the discrimination of the Clinical Exam.	Since 2018, CE examiners undertake training in assessing this exam.	RACS is monitoring discrimination, and aspects that affect discrimination including examiner performance and exam delivery. Data analysis will be conducted in early 2020.	
3. Standard Setting methods for all exams should be evidence-based, and analysis of cut-score performance should be carried out for Specialty Specific Exams with predetermined cut-scores.	Standard-setting methods for all RACS specialty-specific examinations were reviewed in 2019. Most RACS specialties have participated in, workshops regarding evidence-based standard setting methods.	RACS specialties will report to the SSE Committee and/or to the relevant RACS STB regarding the standard-setting methods to be adopted and the time-frame for adoption in 2020. P&RS Plastic and Reconstructive Surgical Science and Principles Exam (PRSSP) committee (Au and NZ) will review standard setting in 2020.	

Examinations recommendations	RACS initiatives in response	RACS planned initiatives	Recommendation rejected with explanation
4. Marking guidelines may need to be addressed for Fellowship Exam components that are performing poorly in inter-rater reliability.	Marking guidelines were reviewed and examiner training was undertaken in 2018 and 2019.		
5. Reliability analysis of Fellowship Exam components should be carried out to identify components that do not correlate well with overall exam performance.	Analysis has been conducted since 2018 of RACS GS FEx results and reported to RACS GS Court of Examiners.		Although reliability analysis is appropriate for FEx, this requires a minimum sample size, which may not be met by many RACS specialties.
6. Specialties should consider the use of alternatives, (e.g. MCQs) instead of essay questions in the Fellowship Exam due to very poor inter-rater reliability in the written components.		Investigation of alternative question types (e.g. short answer questions) and examiner training is planned for 2020-2021.	Court of Examiners is cautious about testing higher level reasoning with MCQs. Examiner training may improve inter-rater reliability.
7. For those specialties with enough candidates, analysis of examiner performance (i.e. stringency) should be carried out for the Fellowship Exam.		Analysis of examiner performance is planned for 2020-2021.	Analysis of examiner performance requires a minimum sample size, which may not be met by many RACS specialties.

Appendix 7 Summary of evaluations and main issues arising

Table 17 Evaluation activities July 2018-June 2019

Evaluation activity	Instigated by	Issues arising	College response to issues
<p>Building Respect Improving Patient Safety:</p> <p>Evaluation framework development complete.</p> <p>Phase 1 evaluation conducted.</p>	RACS Council	<p>Evaluation Framework approved by RACS Council.</p> <p>Full report of phase 1 evaluation attached (Appendix 3).</p> <p>The report findings are extremely positive. The initiative is tracking to plan; reporting and monitoring are contributing to appropriate governance. Key Issue arising is lack of confidence by complainants in the complaints processes and fear of formalising complaints.</p> <p>Trainee engagement has emerged as an area requiring increased focus.</p>	<p>RACS conducted a workshop involving Council representatives and key stakeholders, to inform development of a revised complaints management process.</p> <p>Implications of the changed process to operations, communications, risk and data collection are being mapped.</p> <p>Changed process is being implemented progressively.</p> <p>Ways to improve trainee engagement will be a priority to be addressed as we respond to the findings of the phase one evaluation.</p>
Specialist Training Program (STP) Post Review	Department of Health (DoH)	The DoH mandated a review of all 2017 STP posts to ensure that they still met the current STP eligibility criteria. Any hospital posts considered both public and metropolitan risked defunding.	RACS STP team engaged a project officer to undertake a review of all 2017 STP Posts. RACS has submitted this to the DoH and recommended that six of the eight public/metro posts be defunded in 2021, and the remaining two be continued due to unique training benefits.
Evaluation of standard-setting of specialty-specific exams	AMC Condition 16	RACS specialties have adopted a variety of approaches to standard-setting for specialty-specific exams (to determine the cut-score/pass mark).	RACS has conducted research into best practice standard setting methods, has reviewed RACS specialties' approaches, and has implemented workshops to report on recommended methods and to trial these with specialty SME panels.

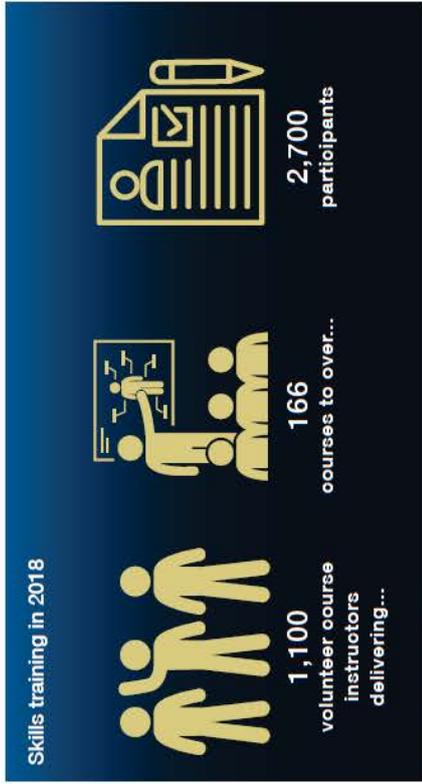
Evaluation activity	Instigated by	Issues arising	College response to issues
Review of barriers and drivers for women becoming surgeons	Building respect, improving patient safety action plan	Previous research shows that females comprise around 55% of students in medical school, but only 30% of applicants to surgical training in Au and NZ.	<p>In 2017/2018, RACS commissioned a pilot study in which 45 women were interviewed to identify barriers and drivers to considering surgical careers.</p> <p>In 2018/19, RACS developed and deployed an online survey for female medical students and junior doctors in Australia; 1,695 responses were received.</p> <p>Preliminary quantitative analysis identified the top five barriers and drivers for women in surgery.</p> <p>Further qualitative analysis is in progress.</p>
Review of survey methods and tools used by RACS	RACS	Multiple survey tools and methods are used throughout RACS. Consider efficiencies deriving from streamlining tools and processes.	Review is in progress.
Skills courses for SET trainees (ASSET, CCrISP, CLEAR, EMST and TIPS)	RACS	Skills courses require standardised faculty evaluation tool, including ongoing opportunity to provide feedback into future curriculum editions outside the pilot period	Standard tool developed by Skills Training and EDRD. All faculty are surveyed post-course, with opportunities to provide feedback on curriculum, for review by committee during next development cycle.

Evaluation activity	Instigated by	Issues arising	College response to issues
Ongoing review of PD courses	Professional Development Department	Ongoing reflection and planning for new courses	<p>Feedback regarding <i>Foundation Skills for Surgical Educators</i> (FSSE) prompted a pilot: <i>Promoting Advances in Surgical Education</i> (PrASE).</p> <p>Feedback regarding <i>Advanced Feedback in Surgical Education</i> prompted a pilot: <i>Managing Difficult Conversations in the Underperforming Trainee</i> (MDC-UT).</p> <p>Briefing and debrief meetings held for PD faculty.</p>
Pilot course evaluation framework	Professional Development Department	<p>RACS needs a consistent way to monitor and evaluate courses.</p> <p>Course evaluation dashboard captures data from 14 sources.</p> <p>Faculty and SME feedback is not (yet) captured consistently across courses.</p>	<p>Framework being developed to integrate a comprehensive course evaluation dashboard with the course review schedule.</p> <p>Aims to build relationships to stay abreast of changes in surgical education; and to monitor relationships between course objectives and the 9 RACS competencies.</p> <p>Currently piloting the dashboard, during first three quarters of 2019. Review dashboard in fourth quarter of 2019.</p>
RACS Activities Report 2018	Fellowship Services Committee	Issues of note include an increase in successful female SET applicants from 30% in 2017 to 34% in 2018	The College is currently reviewing our <i>Diversity and Inclusion Plan</i> with a focus on gender balance in training and Fellowship.

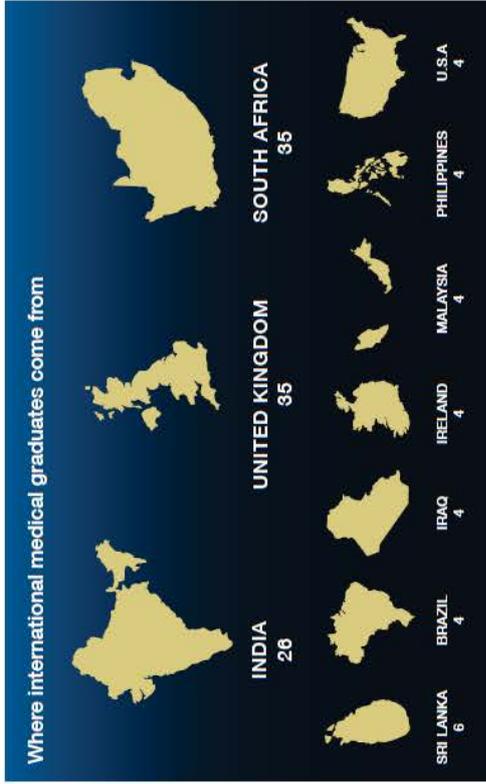
Evaluation activity	Instigated by	Issues arising	College response to issues
RACS Census 2018	Fellowship Services Committee	1,961 active Fellows contributed to the census. Fellows indicated an average work week of 50 hours in 2018 (51 in 2016). 60% of Fellows work in both public and private practice. Consistent with previous reports, Fellows working in public practice report spending more time on administrative functions and fewer Fellows in the private sector undertake emergency on-call work.	Surgeons' health is an area of concern for RACS. Over the past two years RACS has run a "Do you have a GP?" campaign. RACS is finalising a review of our position on safe working hours for surgeons. In June 2019, Council approved development of a surgeons' health working group to look holistically at related issues.
Younger Fellows New Fellow Survey 2018	Younger Fellows Committee	516 Younger Fellows (those in first 10 years of practice) provided feedback on their training experiences and workforce intentions. 97.8% reported their training experience as 'Good' to 'Excellent'. Key barriers to rural/regional practice were highlighted as 'incompatible with specialty', 'unsupportive family /reluctance to move away from family /support networks'.	The Younger Fellows Committee is focusing on provision of additional supports for the transition to Fellowship for new Fellows. The Rural Surgery Section has engaged across specialties and jurisdictional governments to develop strategies to encourage new Fellows to undertake rural/regional careers. New funding /support models are being tailored for implementation.
Annual selection review reports for specialty training (2018 intake)	RACS	Identify poor discrimination and possible bias in the referee report (RR) selection tool.	For 2020 selection intake, four STBs (NSA, URO, ASOHNS and NZOHNS) undertook telephone interviews of referees. Early indications reported by ASOHNS suggest that this approach has encouraged more authentic reporting than was achieved with the online format. This year's data indicate a greater range of scores in the RR than was achieved in 2018. Randomisation of questions and re-ordering of scoring options was introduced to this year's online RRs.

Evaluation activity	Instigated by	Issues arising	College response to issues
RACS Trainees' Association (RACSTA) survey evaluation	RACSTA	<p>Main issues arising from the five-year review included existence of discrimination, bullying and sexual harassment (DBSH).</p> <p>RACSTA survey evaluation identified response rates may have been affected by concurrent specialty surveys.</p>	<p>Summary executive evaluation reports have been distributed to all STBs. A project is now underway to develop a 'dashboard' to provide data at the hospital level to identify any DBSH related issues. This will help inform specialty inspection teams when making decisions on surgical training post accreditation.</p>
Clinical Examination (CE) and Generic Surgical Science Exam (GSSE) feedback reports	RACS	<p>Trainees who are unsuccessful in the CE or GSSE have been at risk of being dismissed from SET. Feedback reports for unsuccessful candidates provided limited information to assist candidates to focus their activities to improve their performance.</p>	<p>Feedback reports for the CE and GSSE will be reviewed in 2020 to ensure that supervisors/mentors have clear information to guide candidates' learning goals to better address identified areas for improvement.</p>
Fellowship Examination (FEx) feedback report	RACS	<p>Trainees and IMGs who are unsuccessful in the FEx require comprehensive, constructive feedback to guide preparation for further attempts. Feedback for unsuccessful candidates has provided limited information.</p>	<p>The FEx feedback was reviewed in 2018. Feedback is now provided regarding strengths and areas for improvement. This feedback is intended to guide candidates, supervisors and STBs in preparation for future attempts.</p> <p>Guidelines were introduced in 2019:</p> <ul style="list-style-type: none"> • Guidelines for Senior Examiners • Guidelines for Examiners • Guidelines for Supervisors <p>In contrast to previous years, in 2019 no requests for additional feedback information were received by the Examination Department from candidates or supervisors.</p>

2018 SNAPSHOT



For further information, see Section One

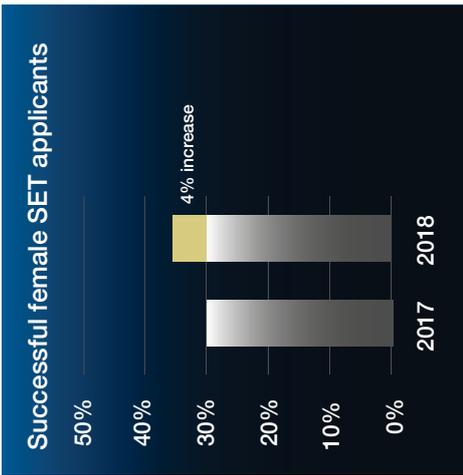


For further information, see Section Two

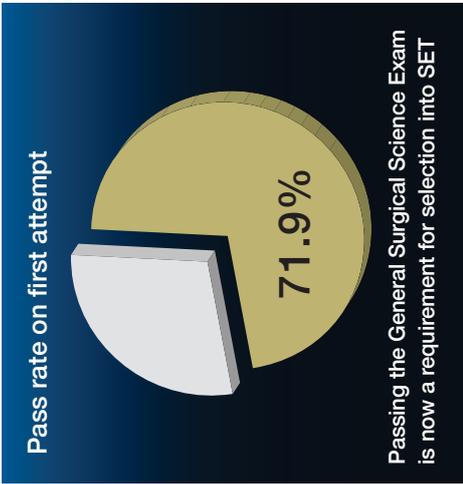
Royal Australasian College of Surgeons

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For further information, see Section Three



For further information, see Section Four



For further information, see Section Five

FOREWORD TO THE ACTIVITIES REPORT

The Activities Report provides detail of the surgical workforce and its distribution as well as information regarding surgical training and examination results. The report is a document provided for Government departments of health, related agencies and those with an interest in the activities of RACS. The data provided in this report is true and accurate as at December 2018.

In 2018, 223 new Australian and New Zealand Fellows were admitted to RACS. This increases the number of active Fellows to over 6400. We also had almost 1200 surgical trainees and 72 International Medical Graduates participate in surgical training over the course of the year.

RACS continues to implement the Building Respect and Improving Patient Safety Action Plan with additional training requirements added to our Continuing Professional Development Program. We are proud of the achievements we have made in this area to ensure the upskilling of surgical supervisors and trainers, and to promote a respectful culture within surgery.



Mr. Anthony Sparnon
President
Royal Australasian College of Surgeons

The Royal Australasian College of Surgeons (RACS), formed in 1927, is a non-profit organisation training surgeons and maintaining surgical standards in Australia and New Zealand. The College's purpose is to be the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand.

RACS works in partnership with specialist surgical societies and associations to train medical doctors to become surgeons and to deliver professional development activities to maintain the surgical skills and standards of our Fellows. We also work with governments, hospitals and other organisations to ensure a well-qualified, experienced and appropriately distributed workforce in Australia and New Zealand.

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ACRONYMS

~	Not available	O/S	Overseas
ACT	Australian Capital Territory	OPBS	Orthopaedic Principles and Basic Science Examination
AOA	Australian Orthopaedic Association	OSCE	Objective Structured Clinical Examinations
ASSET	Australian and New Zealand Surgical Skills Education and Training	OTO	Otolaryngology - Head and Neck Surgery
AUS	Australia	OWR	Operating with Respect
CAR	Cardiothoracic Surgery	PAE	Paediatric Surgery
CCrISP	Care of the Critically Ill Surgical Patient	PAEE	Paediatric Anatomy & Embryology Examination
CE	Clinical Examination	PPPE	Paediatric Pathology & Pathophysiology Examination
CLE	Clinical Epidemiology	PGY	Post Graduate Year/Medical Graduate
CLEAR	Critical Literature Evaluation and Research	PIP	Pacific Islands Projects
CPD	Continuing Professional Development	PLA	Plastic and Reconstructive Surgery
EMST	Early Management of Severe Trauma	PRSSP	Plastic Surgical Science and Principles Exam
GEN	General Surgery	QLD	Queensland
GP	General Practitioner	RACS	Royal Australasian College Of Surgeons
GSSE	Generic Surgical Science Examinations	RRMA	Rural, Remote and Metropolitan Areas
HECS	Health Education and Clinical Services	SA	South Australia
HF	Honorary Fellow	SET	Surgical Education Training
IMG	International Medical Graduate	SSE	Surgical Science Examination
MCNZ	Medical Council of New Zealand	SEAM	Surgical Education and Assessment Modules
MOPS	Maintenance of Professional Standards	STST	Short Term Specified Training
NEU	Neurosurgery	TAS	Tasmania
No.	Number	TIPS	Training in Professional Skills
NSW	New South Wales	URO	Urology Surgery
NT	Northern Territory	VAS	Vascular Surgery
NZ	New Zealand	VIC	Victoria
OB & GYN	Obstetrics and Gynaecology	WA	Western Australia
OPH	Ophthalmology	WFD	Workforce Distribution
ORT	Orthopaedic Surgery		

INTRODUCTION

The Royal Australasian College of Surgeons Activities Report outlines the demographic data for the year 2018. As with previous reports, the purpose is to provide a comprehensive review of RACS activities throughout the year.

This report details activity in the following six sections:

- Section One:** Skills Training
- Section Two:** International Medical Graduates
- Section Three:** Surgical Education and Training
- Section Four:** Examinations
- Section Five:** Workforce Distribution
- Section Six:** Professional Development and Standards

KEY DEVELOPMENTS FOR 2018

The number of female surgeons in active practice increased by 6% in the last year, with women making up just over 13% of the active surgical workforce and more than 23% of the cohort who obtained RACS Fellowship in 2018.

The number of individual female SET applicants continues to comprise almost one-third of all individual applicants. There were 262 applicants who were offered a trainee position in 2018. Over 34% of successful applicants were female in 2018 compared to 30% in 2017.

Each section reviews the purpose of and key findings in the data. This is followed by the data in table and graphical format where possible. Each of the six sections in this report and the data selected has been provided to facilitate a review of activities. All data presented is for the year 2018, unless otherwise stated. All data has been extracted from a copy of the RACS membership database taken on 31 December 2019.

There were over 1600 participants who attended Professional Development programs in 2018, more in line with the number of participants in 2016. In 2017, there were over 3700 Professional Development program participants due to the extra number of 'Foundation Skills for Surgical Educators' courses held during the year to ensure all Fellows involved in surgical training had an opportunity to complete the course, a mandatory requirement for those teaching. SET training or supervising IMGs, as part of the Building Respect, Improving Patient Safety Action Plan. In 2017, 97% of Fellows complied with the RACS CPD program.

SECTION ONE

SKILLS TRAINING

EXPLANATORY NOTES

The Skills Training Department provides the following short courses:

- > Australian and New Zealand Surgical Skills Education and Training (ASSET)
- > Care of the Critically Ill Surgical Patient (CCrISP)
- > Critical Literature Evaluation and Research (CLEAR)
- > Early Management of Severe Trauma (EMST)
- > Training in Professional Skills (TIPS)
- > Operating with Respect (OWR)

Most of these courses are a mandatory requirement of Surgical Education and Training (SET). Doctors from a variety of medical disciplines are involved as both faculty and participants.

These courses incorporate a mix of formative and summative assessment, with participants closely mentored and their performance appraised throughout the courses. Courses that incorporate summative assessment (pass or fail) also have an avenue for feedback to be given to SET and IMG surgical supervisors when required.

Successfully completing the Operating with Respect course is a mandatory requirement for SET Supervisors, IMG Clinical Assessors and members of education and training RACS committees.

ASSET

ASSET is a requirement for all SET Trainees (excluding Neurosurgery). The course provides an educational package of generic surgical skills with an emphasis on small group teaching, intensive hands-on practice of basic skills, individual tuition, personal feedback to participants and the performance of practical procedures. Although this course is not formally assessed, attendees are required to attend and interact in all components for successful completion. Participants are required to complete ten eLearning modules prior to attending the course, and are provided with a suture jig and disposable instruments with which to practice.

CCrISP@

CCrISP@ is a requirement for all SET Trainees. The course focuses on developing systematic skills for managing critically ill patients and promotes the co-ordination of multidisciplinary care where appropriate. The CCrISP@ course encourages doctors to adopt a system of assessment to avoid errors and omissions, and uses relevant clinical scenarios to reinforce the objectives. Participants are assessed by their contribution to the various sections throughout the course, as well as their performance in a 45-minute simulated patient scenario.

EMST

EMST is a requirement for all SET Trainees. EMST focuses on the management of injury victims in the first one to two hours post-accident, with emphasis on life-saving skills and a systematic clinical approach. This course is assessed by contribution to the various interactive discussions, skill stations, a 40-question multiple choice questionnaire paper, and a 15-minute simulated patient scenario.

CLEAR

CLEAR is a requirement for General, Urology, Neurosurgery, Paediatric and New Zealand Orthopaedic SET Trainees. It is designed to provide tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials, aiming to make the language and methodology relevant to surgeons and the day-to-day activities in their practice. There is no formal assessment for this course; participants are required to attend and interact in all components in order to achieve certification. A dedicated consultant only course is run each year to cater to Fellows interested in attending.

TABLE ST.1 – Skills training course attendance by month and course

Month and Course	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL 2018	TOTAL 2017	% change	
CCHSP Instructor Course	Courses	0	0	0	0	0	1	0	0	0	0	0	1	2	-50	
	Instructors	0	0	0	0	0	0	0	0	0	0	0	0	6	-60	
	Participants	0	0	0	0	0	0	0	0	0	0	0	0	8	-71.4	
CCHSP Provider Course	Courses	0	2	2	2	2	3	2	3	2	4	3	0	25	26	-3.8
	Instructors	0	31	28	30	25	36	28	40	26	53	40	0	337	328	2.7
	Participants	0	32	32	32	32	44	32	48	29	65	47	0	393	387	-1.0
EMST ADF Course	Courses	0	1	0	0	1	0	0	1	0	0	1	0	4	4	0
	Instructors	0	10	0	0	12	0	0	11	0	0	11	0	44	39	12.8
	Participants	0	14	0	0	15	0	0	15	0	0	16	0	60	62	-3.2
EMST Instructor Course	Courses	0	0	1	0	0	0	0	0	0	0	1	0	2	2	0
	Instructors	0	0	7	0	0	0	0	0	0	0	8	0	15	16	-6.3
	Participants	0	0	10	0	0	0	0	0	0	0	15	0	25	29	-13.8
EMST Provider Course	Courses	0	3	7	3	4	8	5	3	2	9	8	1	53	52	1.9
	Instructors	0	32	79	31	45	88	57	32	21	95	83	9	572	517	10.6
	Participants	0	48	106	45	63	119	81	38	32	139	98	16	785	784	-1.1
EMST Refresher Course	Courses	0	0	1	1	1	0	0	1	1	0	1	0	6	6	0
	Instructors	0	0	10	9	11	0	0	11	11	0	9	0	61	59	3.4
	Participants	0	0	16	14	10	0	0	16	15	0	16	0	87	85	2.4
ASSET	Courses	6	2	2	4	3	0	0	1	0	4	0	0	22	24	-8.3
	Instructors	109	35	38	67	51	0	0	16	0	66	0	0	382	423	-9.7
	Participants	115	40	40	74	57	0	0	10	0	79	0	0	415	464	-10.6
CLEAR	Courses	0	1	1	0	2	1	0	1	1	2	0	0	10	10	0
	Instructors	0	5	3	0	8	4	0	5	4	5	6	0	40	45	-11.1
	Participants	0	19	28	0	37	16	0	24	28	22	42	0	216	223	-3.1
TIPS Instructor Course	Courses	0	0	0	1	0	0	0	0	0	0	0	1	1	0	
	Instructors	0	0	0	6	0	0	0	0	0	0	0	0	6	8	-25
	Participants	0	0	0	9	0	0	0	0	0	0	0	0	9	14	-35.7
TIPS Provider Course	Courses	0	1	1	1	1	0	1	1	1	2	0	0	10	10	0
	Instructors	0	9	9	9	8	0	9	9	8	10	18	0	89	96	-7.3
	Participants	0	12	12	12	12	0	12	9	11	16	24	0	120	104	15.4
OWR Instructor Course	Courses	0	1	0	0	0	0	1	0	0	1	0	0	3	2	50
	Instructors	0	5	0	0	0	0	3	0	0	3	0	0	11	12	-8.3
	Participants	0	8	0	0	0	0	5	0	0	4	0	0	17	19	-10.5
OWR Provider Course	Courses	0	3	4	0	3	3	3	1	4	3	3	2	29	14	107.1
	Instructors	0	14	17	0	16	13	14	4	19	15	16	10	138	70	97.1
	Participants	0	66	59	0	67	60	70	20	91	59	65	40	597	256	133.2
Total	Courses	6	14	19	12	17	15	13	12	11	23	21	3	166	153	8.5
	Instructors	109	141	191	152	176	141	117	128	89	247	191	19	1701	1628	4.5
	Participants	115	239	303	186	293	239	208	180	206	364	323	56	2732	2475	10.4

Note: Number of instructors documented in this table is the number of instructors per course. A number of instructors teach on multiple courses therefore the number of individual instructors is lower.

Faculty

The skills course volunteer workforce comprises of 1158 faculty members. Instructors are represented across all disciplines of medicine and surgery, with 167 (14%) teaching on more than one program. Representation of Fellows teaching on skills courses remains at 58% (N=676) with 2% (N=27) SET Trainees, 1% (N=10) International Medical Graduates and the remaining 39% (N=445) consisting of emergency physicians, anaesthetists, physicians, intensivists, general practitioners, clinical epidemiologists and educators. The EMST and CCHSP@ faculty include instructors local to Fiji and Papua New Guinea where outreach courses are held.

TIPS

TIPS is a requirement for Australian-based orthopaedic SET Trainees. TIPS focuses on patient-centred communication and team-oriented, non-technical skills in surgery. Through simulation, participants address issues and events that occur in the clinical and operating theatre environment that require skills in communication, teamwork, crisis resource management and leadership. TIPS is designed to be generic to all specialities of surgical training and relevant to Trainees who have already undertaken 2 to 3 years of surgical training. There is no formal assessment for this course; participants are provided with direct feedback throughout the course and are required to attend all components to achieve certification. TIPS is a requirement for SET Trainees undertaking the Australian orthopaedic training program from 2017. TIPS participants are required to complete the JDocs Communication eLearning module prior to attending.

OWR

Frist launched in 2017, the Operating with Respect course is a mandatory requirement for all SET Supervisors, IMG Clinical Assessors and key RACS committee members by the end of 2018. OWR provides advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment. The aim of this course is to strengthen patient safety by enabling participants to develop skills in respectful behaviour and practice strategies in responding to unacceptable behaviour. The course follows the release of the RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery.

TABLE ST.2 – Skills training course attendance by location and course

Month and Course	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S*	TOTAL 2018	TOTAL 2017	% Change 17/18
CCRSP Instructor Course	0	0	0	0	0	0	1	0	1	0	0	1	2	-50
Instructors	0	0	0	0	0	0	6	0	6	0	0	6	15	-60
Participants	0	0	0	0	0	0	8	0	8	0	0	8	28	-71.4
CCRSP Provider Course	0	5	0	5	2	0	6	1	19	5	1	25	26	-3.8
Instructors	0	65	0	68	28	0	90	15	266	61	10	337	328	2.7
Participants	0	80	0	81	32	0	94	16	303	78	12	393	397	-1.0
EMST ADF Course	0	4	0	0	0	0	0	0	4	0	0	4	4	0
Instructors	0	44	0	0	0	0	0	0	44	0	0	44	39	12.8
Participants	0	60	0	0	0	0	0	0	60	0	0	60	62	-3.2
EMST Instructor Course	0	0	0	0	0	0	2	0	2	0	0	2	2	0
Instructors	0	0	0	0	0	0	15	0	15	0	0	15	16	-6.3
Participants	0	0	0	0	0	0	25	0	25	0	0	25	29	-13.8
EMST Provider Course	1	13	0	10	4	1	10	3	42	10	1	53	52	1.9
Instructors	8	141	0	108	44	11	110	35	457	105	10	572	517	10.6
Participants	12	182	0	142	63	16	155	46	616	162	7	785	794	-1.1
EMST Refresher Course	0	2	0	1	1	0	1	-	5	1	0	6	6	0
Instructors	0	19	0	11	9	0	11	-	50	11	0	61	59	3.4
Participants	0	32	0	16	14	0	10	-	72	15	0	87	85	2.4
ASSET	0	6	0	4	2	0	6	1	19	3	0	22	24	-8.3
Instructors	0	103	0	70	32	0	113	15	333	49	0	382	423	-9.7
Participants	0	119	0	80	30	0	120	17	366	49	0	415	464	-10.6
CLEAR	0	3	0	1	1	0	3	0	8	2	0	10	10	0
Instructors	0	13	0	5	3	0	11	0	32	8	0	40	45	-11.1
Participants	0	59	0	22	17	0	72	0	170	46	0	216	223	-3.1
TIPS Instructor Course	0	0	0	0	0	0	1	0	1	0	0	1	1	0
Instructors	0	0	0	0	0	0	6	0	6	0	0	6	8	-25
Participants	0	0	0	0	0	0	9	0	9	0	0	9	14	-35.7
TIPS Provider Course	0	2	0	1	1	0	3	1	8	2	0	10	10	0
Instructors	0	19	0	9	8	0	24	9	69	20	0	89	96	-7.3
Participants	0	28	0	12	12	0	35	9	96	24	0	120	104	15.4
OWR Instructor Course	0	0	0	0	0	0	1	0	1	0	2	3	2	50
Instructors	0	0	0	0	0	0	5	0	5	0	6	11	12	-8.3
Participants	0	0	0	0	0	0	8	0	8	0	9	17	19	-10.5
OWR Provider Course	1	6	0	3	2	1	6	3	22	4	3	29	14	107.1
Instructors	5	28	0	14	10	6	28	14	105	18	15	138	70	97.1
Participants	19	135	0	65	45	19	127	47	457	76	64	597	256	133.2
Courses	2	41	0	25	13	2	40	9	132	27	7	166	153	8.5
Instructors	13	432	0	285	134	17	419	88	1388	272	41	1701	1628	4.5
Participants	31	695	0	418	213	35	663	135	2190	450	92	2732	2475	10.4

Note: Number of instructors documented in this table is the number of instructors per course. A number of instructors teach on multiple courses therefore the number of individual instructors is lower.

TABLE ST.3 – ASSET faculty by location and speciality

Location & Speciality	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% change 17/18
CAR	0	1	0	4	1	0	4	2	12	1	0	13	12	8.3
GEN	1	50	1	24	14	7	49	15	161	31	2	194	176	10.2
NEU	0	1	0	5	1	0	0	1	8	0	0	8	7	14.3
ORT	1	18	0	10	2	0	17	2	50	24	0	74	74	0
OTO	0	5	0	4	3	0	0	3	15	5	2	22	23	-4.3
PAE	0	6	0	0	1	1	1	1	10	4	0	14	12	16.7
PLA	1	6	0	6	3	0	8	1	25	4	1	30	30	0
URO	1	2	0	2	3	0	7	2	17	4	0	21	19	10.5
IVAS	0	4	0	2	1	2	3	3	15	1	1	17	19	-10.5
Sub Total	4	93	1	57	29	10	89	30	313	74	6	393	372	5.6
IMG	0	6	0	1	0	0	2	0	9	1	0	10	4	150
SET	0	0	0	0	0	0	0	0	0	4	0	4	8	-50
Other	0	0	0	0	0	0	0	1	1	0	1	2	2	0
OPH	0	1	0	0	0	0	0	0	1	0	0	1	1	0
TOTAL	4	100	1	58	29	10	91	31	324	79	7	410	387	5.9

TABLE ST.4 – CCRISP faculty by location and medical discipline

Location & Discipline	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% change 17/18
Anesthesia	0	7	0	7	2	0	7	4	27	22	5	54	52	3.8
Emergency Medicine	2	1	0	5	4	1	2	2	17	0	0	17	20	-15
General Practice	0	3	0	1	0	0	0	1	5	0	0	5	5	0
Intensive Care	2	9	0	2	1	2	3	3	22	2	0	24	30	-20
Physician	0	0	0	0	2	0	0	0	2	1	0	3	6	-50
Surgery	1	31	1	29	8	3	32	16	121	43	15	179	183	-2.2
Other	0	0	0	0	0	0	0	0	0	0	0	0	1	-100
Total	5	51	1	44	17	6	44	26	194	68	20	282	297	-5.1

TABLE ST.5 – EMST faculty by location and medical discipline

Location & Medical Discipline	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% change 17/18
Anesthesia	1	29	1	14	3	2	21	3	74	7	3	84	89	-5.6
Emergency Medicine	7	37	3	17	15	2	21	19	121	25	1	147	157	-6.4
General Practice	1	5	1	11	4	1	6	4	33	4	0	37	43	-14
Intensive Care	1	8	1	12	6	0	11	1	40	5	1	46	46	0
Surgery	3	53	1	19	7	3	29	13	128	28	15	171	182	-6
Other	0	2	0	1	1	0	0	1	5	0	2	7	5	40
Total	13	134	7	74	36	8	88	41	401	69	22	492	522	-5.7

TABLE ST.6 – CCrISP and EMST attendance by location and pass rate

Location and Course	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	OS	TOTAL 2018	TOTAL 2017	% Change 17/18
CCrISP														
Attended	6	99	2	67	20	4	84	21	303	86	12	401	424	-5.4
Pass	6	97	2	66	20	4	82	21	298	85	12	395	396	-0.3
%	100%	98%	100%	99%	100%	100%	98%	100%	98%	99%	100%	99%	93%	5.5
EMST														
Attended	24	241	11	171	59	15	155	55	731	214	12	957	1041	-8.1
Pass	21	225	10	158	54	13	144	54	679	210	12	901	931	-3.2
%	88%	93%	91%	92%	92%	87%	93%	98%	93%	98%	100%	94%	89%	5.3

TABLE ST.7 – CLEAR faculty by location, specialty and medical discipline

Location, Specialty & Discipline	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017
CAR	0	1	0	0	0	0	1	0	2	0	0	2	3
GEN	0	4	0	1	0	3	0	1	9	2	0	11	11
NEU	0	1	0	0	0	0	0	0	1	0	0	1	1
ORT	0	3	0	1	0	0	1	0	5	2	0	7	6
OTO	0	0	0	0	0	0	0	0	0	0	0	0	0
PAE	0	0	0	0	0	0	0	0	0	0	0	0	1
PLA	0	0	0	0	0	0	1	0	1	0	0	1	1
URO	0	1	0	0	0	0	0	0	1	0	0	1	1
VAS	0	1	0	0	0	0	0	0	1	0	0	1	1
Sub Total	0	11	0	2	0	3	3	1	20	4	0	24	25
*CLE	0	1	0	1	0	1	1	0	4	1	0	5	6
Total	0	12	0	3	0	4	4	1	24	5	0	29	31

*CLE – Clinical Epidemiologist

TABLE ST.8 – TIPS faculty by location and medical discipline

Location & Medical Discipline	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017
Anesthesia	-	2	0	-	1	0	-	-	3	0	0	3	2
Emergency Medicine	-	-	0	2	1	0	2	-	5	0	0	5	4
General Practice	0	0	0	0	0	0	0	0	0	0	0	0	0
Physician	-	-	0	-	1	0	-	-	1	1	0	2	1
Intensive Care	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	1	10	0	7	8	0	10	2	38	12	0	50	41
Other	-	-	0	-	1	0	3	-	4	0	0	4	11
Total	1	12	0	9	12	0	15	2	51	13	0	64	59

TABLE ST.9 – OWR Faculty by region, specialty and medical discipline

Location, Specialty & Discipline	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017
CAR	0	0	0	0	0	0	0	1	1	0	0	1	1
GEN	0	3	0	6	2	1	3	2	17	2	0	19	11
NEU	0	2	0	1	0	0	1	0	4	0	0	4	3
ORT	0	2	0	1	0	0	0	0	3	1	0	4	2
OTO	0	0	0	1	0	0	1	0	2	1	0	3	2
PAE	0	1	0	1	0	0	0	0	2	2	0	4	3
PLA	0	0	0	0	0	0	0	0	0	0	0	0	0
URO	0	0	0	0	0	0	0	0	0	0	0	0	0
VAS	0	0	0	0	0	0	0	0	0	1	0	1	1
Sub Total	0	8	0	10	2	1	5	3	29	7	0	36	23
INTENSIVIST	1	0	0	0	0	0	0	0	1	0	0	1	1
Total	1	8	0	10	2	1	5	3	30	7	0	37	24

SECTION TWO

INTERNATIONAL MEDICAL GRADUATES

EXPLANATORY NOTES

Australia

RACS is accredited by the Australian Medical Council (AMC) to train surgeons and maintain surgical standards. International Medical Graduates (IMGs) with formal postgraduate specialist qualifications in surgery who wish to work in Australia, apply to RACS for an assessment of their qualifications and experience. The RACS IMG assessment process for specialist recognition and Fellowship of RACS evaluates the training, qualifications and experience of the IMG for comparability with an Australian or New Zealand trained surgeon.

The processes for assessing the comparability of International Medical Graduates (IMGs) to holders of RACS Fellowship, and for practice as surgeons in Australia are in accordance with the principles outlined in the following publications:

- > RACS – Specialist Assessment of International Medical Graduates in Australia policy <https://www.surgeons.org/policies-publications/policies/international-medical-graduates/>
- > RACS – IMG Area of Need Assessment policy <https://www.surgeons.org/policies-publications/policies/international-medical-graduates/>
- > Australian Medical Council (AMC) – Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the AMC 2015
- > AMC Standards for Assessment
- > Medical Board of Australia (MBA) Guidelines - Good practice guidelines for the specialist international medical graduate assessment process <http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Specialist-Pathway.aspx>

International Medical Graduates – Period of Clinical Assessment

The process related to the period of clinical assessment for IMGs are in accordance with the principles outlined in the following publications:

- > RACS Assessment of the Clinical Practice of IMGs in Australia policy; <https://www.surgeons.org/policies-publications/policies/international-medical-graduates/> and
- > MBA Guidelines - Supervised practice for international medical graduates <http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>

International Medical Graduates Short Term Training in a Medical Specialty Pathway

Short-term training programs in Australia allow IMGs the opportunity to undertake a short-term training program not available in their country of training with the objective of improving

their professional skills and experience. Within the surgical specialty, an IMG approved to undertake a short-term training position/program can develop surgical skills and experience through a work based surgical program provided by the hospital.

The process related to the short-term training program for IMGs is in accordance with the principles outlined in the following publications:

- > Short Term Training in a Medical Specialty Pathway policy <https://www.surgeons.org/policies-publications/policies/international-medical-graduates/>
- > MBA – Short Term Training in a Medical Specialty Pathway <http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Short-term-training.aspx>

New Zealand

In New Zealand, RACS acts as an agent of, and provides recommendations to, the Medical Council of New Zealand (MCNZ) on applications by IMGs for vocational registration in one of RACS' nine surgical specialties. The provision of preliminary advice, an interview or a review occurs only in response to a request from the MCNZ.

The MCNZ holds statutory responsibility for approving the standard for registration and requests that RACS advise whether an IMG's training, qualifications and experience are equivalent to, or as satisfactory as, those of a locally trained doctor registered in the same vocational scope of surgery.

A recommendation on the IMG's suitability for the vocational registration pathway is provided to the MCNZ to advise if the IMG is suitable for the pathway. The recommendation includes whether the IMG should be placed under MCNZ approved supervision, or undergoes RACS approved assessment to ensure the IMG is at the required standard. The MCNZ considers this and determines the type of medical registration that will be offered to

the IMG and any restrictions or conditions that may be placed on that registration. The MCNZ advises RACS and the IMG of its decision.

If the IMG is required to undertake a RACS approved vocational assessment, RACS is asked to approve the post and the supervisor(s) and the supervisor's reports are sent to RACS and to the MCNZ. Once all assessment requirements have been completed by the IMG, RACS recommends to the MCNZ if the IMG should be approved for inclusion on the vocational register in the relevant specialty.

Admission to Fellowship of the Royal Australasian College of Surgeons is a decision of RACS and it is not part of the vocational registration assessments for the MCNZ. IMGs who have obtained vocational registration in New Zealand may apply to RACS for admission to Fellowship, and the information from the vocational registration process may be considered by RACS in reaching its decision on that application.

Australia

TABLE IMG 1 – Number of International Medical Graduate applications received by specialty

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VIAS	Total 2018
Specialist recognition	3	19	2	12	7	6	6	8	2	65
Area of need	0	0	0	0	1	0	2	0	1	4
Total	3	19	2	12	8	6	8	8	3	69

TABLE IMG 2 – International Medical Graduate Countries of Training

Country	Qualification		Total 2018
	Primary	Specialist	
BELGIUM	0	1	1
BRAZIL	2	2	4
CANADA	1	1	2
CHILE	1	1	2
CHINA	1	0	1
EGYPT	1	1	2
INDIA	13	13	26
IRAN	1	1	2
IRAQ	2	2	4
IRELAND	2	2	4
ITALY	1	0	1
JORDAN	1	1	2
MALAYSIA	2	2	4
PAKISTAN	1	1	2
PHILIPPINES	2	2	4
ROMANIA	1	1	2
RUSSIAN FEDERATION	1	1	2
SAUDI ARABIA	0	1	1
SOUTH AFRICA	9	9	18
SRI LANKA	3	3	6
SUDAN	1	0	1
SYRIA	1	1	2
TAIWAN	0	1	1
THE NETHERLANDS	2	1	3
TRINIDAD	1	0	1
U.S.A.	2	2	4
UNITED KINGDOM	16	19	35
YEMEN	1	0	1
Total	69	69	138

*The country in which the IMG gained their qualification (primary qualification and specialist qualification).

TABLE IMG 3 – Number of International Medical Graduates not comparable after initial paper-based review

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2018
No. of IMGs not comparable	0	2	0	3	1	4	2	2	0	14

Note: IMGs are subject to document-based assessment only. Interview is not required. Data inclusive of applications activated in 2017.

TABLE IMG 4 – Number of applications withdrawn by International Medical Graduates

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2018
Before initial assessment	0	2	0	1	1	0	0	0	1	5
Between initial and final assessment	0	0	0	0	0	0	0	1	0	1
Total	0	2	0	1	1	0	0	1	1	6

Note: Number of IMGs who notify the college that they no longer wish to proceed with their application for specialist assessment.

TABLE IMG 5 – Specialist assessment pathway: International Medical Graduate outcome of initial assessment

Assessment result	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2018
Substantially comparable	0	8	2	2	1	0	1	0	1	15
Partially comparable	3	7	0	6	4	2	3	0	2	27
Not comparable	0	4	0	5	2	4	1	6	0	22
In progress	0	2	0	2	1	0	1	3	0	9
Total	3	21	2	15	8	6	6	9	3	73
Applications activated in 2017	0	2	0	3	1	0	0	1	1	8
Applications activated in 2018	3	19	2	12	7	6	6	8	2	65
Total processed	3	21	2	15	8	6	6	9	3	73

Note: IMG's comparability is based on a limited scope of practice this should be noted. Data inclusive of applications activated in 2017.

TABLE IMG 6 – Specialist assessment pathway: International Medical Graduate specialists under oversight / supervision

Clinical assessment - by specialty												
Supervision / oversight period	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2018		
Currently under oversight	0	0	0	0	0	0	0	1	0	1		
Currently under supervision	0	6	0	3	2	1	0	0	2	14		
Completed oversight/supervision	1	1	0	10	0	0	1	1	0	14		
Total	3	14	4	23	6	2	3	3	3	61		

Clinical assessment - by location of residence

Supervision / oversight period	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	Total 2018
Currently under oversight	0	1	0	0	0	0	0	0	1	0	1
Currently under supervision	0	5	0	7	1	0	1	0	14	1	15
Completed oversight/supervision	0	8	2	8	3	1	7	2	31	0	31
Total	0	17	2	21	5	1	11	3	60	1	61

TABLE IMG 7 – Area of need pathway: International Medical Graduate outcome of initial assessment

Outcome following the college's paper-based review and/or interview as documented in Medical Board of Australia Report 1

Assessment result	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2018
Substantially comparable	0	0	0	0	1	0	0	0	1	2
Partially comparable	0	0	0	0	0	0	1	0	0	1
Not comparable	0	0	0	0	0	0	1	0	0	1
In progress	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	1	0	2	0	1	4
Applications activated in 2017	0	0	0	0	0	0	0	0	0	0
Applications activated in 2018	0	0	0	0	1	0	2	0	1	4
Total processed	0	0	0	0	1	0	2	0	1	4

TABLE IMG 8 – Area of need pathway: International Medical Graduate specialists under oversight/ supervision

Clinical assessment - by speciality													
Supervision/ oversight period	by location of residence												
	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2018			
Currently under oversight	0	0	0	0	0	0	0	0	0	0			
Currently under supervision	0	1	0	1	0	0	0	0	1	3			
Completed oversight/ supervision	0	0	0	1	1	0	2	0	0	4			
Total	0	1	0	5	2	0	2	0	1	11			

Clinical assessment - by location of residence													
Supervision/ oversight period	by location of residence												
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	Total 2018		
Currently under oversight	0	0	0	0	0	0	0	0	0	0	0		
Currently under supervision	0	0	0	1	0	0	1	0	2	0	2		
Completed oversight/ supervision	0	0	1	1	0	2	0	0	0	0	4		
Total	0	0	0	4	0	3	0	11	0	0	11		

TABLE IMG 9 – International Medical Graduate outcome of area of need assessment

Outcome following the college's paper-based review as documented in area of need assessment outcome report or Medical Board of Australia (MBA) Report combined report.

Suitable for area of need position	by location of residence										
	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2018	
Suitable for area of need position	0	0	0	0	1	0	0	0	1	2	
Not suitable for area of need position	0	0	0	0	0	0	2	0	0	2	
Total	0	0	0	0	1	0	2	0	1	4	

TABLE IMG 10 – International Medical Graduate outcome of final assessment

Outcome following the college's final assessment (after the IMG has completed all the requirements in MBA report 1) as documented in Medical Board of Australia Report 2

Recommended for recognition as specialist	by location of residence										
	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2018	
Partially comparable	1	4	0	7	0	0	3	1	1	17	
Substantially comparable	0	8	0	0	3	1	0	0	0	12	
Substantially comparable (limited scope)	0	0	0	0	2	0	0	0	0	2	
Not comparable	0	0	0	0	0	0	0	0	0	0	
Partially comparable	0	2	0	3	3	0	1	1	1	11	
Substantially comparable	0	0	0	0	0	0	0	0	0	0	
Substantially comparable (limited scope)	0	0	0	1	0	0	0	0	0	1	
Not comparable	0	0	0	0	0	0	0	0	0	0	
Total	1	14	0	11	8	1	4	2	2	43	

Note: 'Substantially Comparable (limited scope)' has been added since 2017.

TABLE IMG 11 – International Medical Graduate time for specialist recognition initial assessment

2018
0-3 months
4-6 months
7-12 months
13 months +
Not finalised
Total

TABLE IMG 12 – International Medical Graduate time for area of need assessment

2018
0-3 months
4-6 months
7-12 months
13 months +
Not finalised
Total

TABLE IMG 13 – International Medical Graduate time for specialist recognition final assessment

2018
0-3 months
4-6 months
7-12 months
13-18 months
19-24 months
24 months +
Total

TABLE IMG 14 – International Medical Graduate - number and outcome of appeal

Total number of appeals	2018
Decision being appealed	1
Original decision	1
RACS decision	0
Upheld	1
Overturned	0

Note: Timeframe to complete all requirements as specified in specialist recommendation. Period is noted from date of commencement of clinical assessment. As documented in Medical Board of Australia Report 2.

TABLE IMG 15 – Short-termed specified training: International Medical Graduate specialist applications by speciality

RACS decision	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total 2018
Approved	24	27	13	109	13	8	27	16	10	247
Denied	0	0	0	0	0	0	0	0	0	0
Pending	0	0	0	0	0	0	1	0	0	0
In Process	0	0	0	0	0	0	0	0	0	0
Total	24	27	13	109	13	8	27	16	10	247

TABLE IMG 16 – Short-termed specified training: International Medical Graduate specialist applications by location

RACS decision	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	Total 2018
Approved	1	95	4	23	28	0	68	28	247	0	247
Denied	0	0	0	0	0	0	0	0	0	0	0
Pending	0	0	0	0	0	0	0	0	0	0	0
In Process	0	0	0	0	0	0	0	0	0	0	0
Total	1	95	4	23	28	0	68	28	247	0	247

TABLE IMG 17 – Number of International Medical Graduate specialists practicing in Australia

Total number of IMGs practising in Australia with valid assessment	Total 2018
	72

Note: IMGs undergoing clinical assessment or IMGs who have completed clinical assessment and are required to complete the College's Fellowship Examination and/or other requirements as stipulated in their specialist recommendation following a document based assessment and interview.

New Zealand

TABLE IMG 18 – Applications for International Medical Graduate specialists

Preliminary advice to the MCNZ following documentation review	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL
Likely to Be Suitable for Vocational Pathway	0	1	0	5	2	0	0	0	0	8
Unlikely to Be Suitable for Vocational Pathway	1	1	0	4	1	0	0	1	0	8
Unable to Determine Suitability by Documentation Only	0	1	0	2	0	0	0	0	0	3
Preliminary advice requests not yet completed	0	0	0	0	0	0	0	0	0	0
Total	1	3	0	11	3	0	0	1	0	19

TABLE IMG 19 – Interview outcomes for International Medical Graduate specialists applicants

Advice to MCNZ following interview	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL
Vocational Pathway - Supervision (MCNZ approved)	1	2	0	4	2	0	1	0	0	10
Vocational Pathway - Supervised Assessment (College Approved)	0	2	2	7	4	0	2	0	0	17
Not Recommended As Suitable For Vocational Pathway	0	1	0	1	2	0	1	0	1	6
Total	1	5	2	12	8	0	4	0	1	33

Applications yet to achieve interview completion	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL
Applicants withdrawn prior to interview 2018	0	0	0	0	0	0	0	0	0	0
Applicants awaiting interview at end of December 2018	0	0	0	1	0	0	0	0	0	1
Interview process incomplete at end of December 2018	0	0	0	0	1	0	0	0	0	1
Total	0	0	0	1	1	0	0	0	0	2

TABLE IMG 20 – International Medical Graduate specialists participating in vocational assessment

IMGs under College approved Vocational Assessment in 2018	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL
For Full Scope Registration	0	3	2	5	1	1	0	0	0	12
For Restricted Scope Registration	0	0	0	0	0	0	2	0	0	2
Total	0	3	2	5	1	1	2	0	0	14

College approved vocational assessments completed in 2018	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL
To Satisfactory Standard	0	1	0	1	0	0	0	0	0	2
Not To Satisfactory Standard	0	0	0	0	0	0	0	0	0	0
Withdrawn from program	0	0	0	0	0	0	0	0	0	0
Total	0	1	0	1	0	0	0	0	0	2

TABLE IMG 21 – RACS review of recommendations for International Medical Graduate specialist applicants at the request of the Medical Council of New Zealand

RACS Recommendation after review	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL
Recommendation Altered	0	0	0	1	0	0	1	0	0	2
Recommendation Not Altered	0	0	0	4	1	0	2	0	1	8
In progress	0	1	0	0	0	0	0	0	0	1
Total	0	1	0	5	1	0	3	0	1	11

MCNZ decision of RACS review	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL
RACS review accepted by MCNZ	0	0	0	4	1	0	1	0	1	7
RACS review not accepted by MCNZ	0	0	0	1	0	0	1	0	0	2
In progress	0	0	0	0	0	0	1	0	0	1
Total	0	0	0	5	1	0	3	0	1	10

SECTION THREE

SURGICAL EDUCATION & TRAINING

EXPLANATORY NOTES

The College is accredited to conduct surgical training in nine specialties. The following specialties conduct bi-national training programs:

- > Cardiothoracic Surgery
- > Neurosurgery
- > Paediatric Surgery
- > Urology Surgery; and
- > Vascular Surgery.

Separate programs are conducted in Australia and New Zealand for the following specialties:

- > General Surgery
- > Orthopaedic Surgery
- > Otolaryngology – Head and Neck Surgery; and
- > Plastic and Reconstructive Surgery.

The number of appointments made in any year is dependent on the number of SET Trainees finishing the program and the consequent number of vacant accredited posts. RACS does

not control the number of posts available but accredits posts nominated by jurisdictions. RACS has committed to accrediting any training post that meets the accreditation standards.

Since the introduction of the SET program in 2008 individual specialties have diverged from a common categorisation of Trainee SET level. Consequently this report is based on "years in training" and doesn't reflect individual Trainees' progress towards Fellowship.

The AOA has not notified RACS of the regional or person type breakdown of applications received for the orthopaedic program in Australia. The totals listed in tables SET.1 to SET.4 have been included as Australian applicants only with no regional breakdown and included as Non IMG/Trainees. Also, it is unclear whether applicants to the orthopaedic program in Australia made applications to other specialties (table SET.3).

Active SET Trainees who started training, finished training or were admitted to Fellowship in the middle of the year are not counted as an active Trainee in all tables.

DATA HIGHLIGHTS

SET applications decreased in 2018 by almost 13%, and Plastic and Reconstructive Surgery had the largest increase in applications compared to 2017 (28%). The number of individual female SET applicants comprised almost one-third of all individual applicants (Table SET.3). There were 262 applicants who were offered a Trainee position in 2018. Just over 34% of successful applicants were female, a 4% increase from 2017 (Table SET.5).

TABLE SET 1 – SET applications by specialty, gender and applicant type^a

Specialty & Type	SET	IMG	NON IMG / Trainee ^b	Fellow	TOTAL 2018	TOTAL 2017	% Change 17/18
CAR	Male	0	34	0	34	33	3.0
	Female	1	0	0	9	13	-30.8
	Total	1	0	0	43	46	-6.5
GEN	Male	0	202	0	202	180	12.2
	Female	0	113	0	113	97	16.5
	Total	0	315	0	315	277	13.7
NEU	Male	0	39	0	39	34	14.7
	Female	0	16	0	16	15	6.7
	Total	0	55	0	55	49	12.2
ORTc	Male	0	56	0	56	191	-70.7
	Female	0	17	0	17	34	-50.0
	Total	0	73	0	73	225	-67.6
OTO	Male	1	51	0	52	57	-8.8
	Female	1	27	0	28	23	21.7
	Total	2	78	0	80	80	0.0
PAE	Male	0	10	0	10	10	0.0
	Female	0	11	0	11	14	-21.4
	Total	0	21	0	21	24	-12.5
PLA	Male	3	57	0	60	47	27.7
	Female	0	28	0	28	31	-9.7
	Total	3	85	0	88	78	12.8
URO	Male	5	35	0	40	49	-18.4
	Female	1	22	0	23	13	76.9
	Total	6	57	0	63	62	1.6
VAS	Male	6	25	0	31	31	0.0
	Female	0	7	0	7	17	-58.8
	Total	6	32	0	38	48	-20.8
Total	Male	15	509	0	524	632	-17.1
	Female	3	249	0	252	257	-1.9
	Total	18	758	0	776	889	-12.7

^a Total number of SET applications may include more than one application from an individual.

^b Non-IMG/Trainee refers to applications from those not currently Fellows, Trainees or IMGs.

TABLE SET 2 – SET applications by speciality and location of residence^a

Location & Speciality	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18	
CAR	Male	0	9	0	6	5	0	6	1	27	6	1	34	33	3
	Female	0	4	0	2	0	0	3	0	9	0	0	9	13	-30.8
	Total	0	13	0	8	5	0	9	1	36	6	1	43	46	-6.5
GEN	Male	3	58	7	44	15	0	39	11	177	25	0	202	180	12.2
	Female	3	33	0	20	3	0	32	10	101	12	0	113	97	16.5
	Total	6	91	7	64	18	0	71	21	278	37	0	315	277	13.7
NEU	Male	0	18	0	7	1	3	6	3	38	1	0	39	34	14.7
	Female	0	5	0	2	1	0	6	0	14	2	0	16	15	6.7
	Total	0	23	0	9	2	3	12	3	52	3	0	55	49	12.2
ORT	Male	0	7	0	5	1	1	8	1	23	33	0	56	191	-70.7
	Female	0	1	0	2	1	0	1	2	7	10	0	17	34	-50
	Total	0	8	0	7	2	1	9	3	30	43	0	73	225	-67.6
OTO	Male	1	13	0	8	3	0	17	2	44	8	0	52	57	-8.8
	Female	0	5	0	10	3	0	6	1	25	3	0	28	23	21.7
	Total	1	18	0	18	6	0	23	3	69	11	0	80	80	0
PAE	Male	0	2	0	0	2	0	5	0	9	1	0	10	10	0
	Female	0	3	0	3	0	0	2	0	8	3	0	11	14	-21.4
	Total	0	5	0	3	2	0	7	0	17	4	0	21	24	-12.5
PLA	Male	0	11	0	9	5	1	18	3	47	13	0	60	47	27.7
	Female	0	5	0	4	2	0	12	0	23	5	0	28	31	-9.7
	Total	0	16	0	13	7	1	30	3	70	18	0	88	78	12.8
URO	Male	1	11	0	7	2	0	9	5	35	5	0	40	49	-18.4
	Female	1	4	0	4	1	0	10	0	20	3	0	23	13	76.9
	Total	2	15	0	11	3	0	19	5	55	8	0	63	62	1.6
VAS	Male	0	13	0	6	0	8	1	28	3	0	31	31	0	
	Female	0	2	0	2	1	0	0	1	6	1	0	7	17	-58.8
	Total	0	15	0	8	1	0	8	2	34	4	0	38	48	-20.8
Total	Male	5	142	7	92	34	5	116	27	428	95	1	524	632	-17.1
	Female	4	62	0	49	12	0	72	14	213	39	0	252	257	-1.9
	Total	9	204	7	141	46	5	188	41	641	134	1	776	889	-12.7

^a Total number of SET applications may include more than one application from an individual.

TABLE SET 3 – Individual SET applicants by number of applications and applicant type^a

Number & Type	SET	SET Deferred IMG	NON IMG / Trainee	Fellow	TOTAL 2018	TOTAL 2017	% Change 17/18	
1	Male	15	0	404	0	419	387	8.3
	Female	3	0	214	0	217	194	11.9
	Total	18	0	618	0	636	581	9.5
2	Male	0	0	50	0	50	49	2
	Female	0	0	16	0	16	21	-23.8
	Total	0	0	66	0	66	70	-5.7
3	Male	0	0	1	0	1	4	-75
	Female	0	0	1	0	1	0	-
	Total	0	0	2	0	2	4	-50
≥4	Male	0	0	1	0	1	0	-
	Female	0	0	0	0	0	0	-
	Total	0	0	1	0	1	0	-
Total	Male	15	0	456	0	471	440	7
	Female	3	0	231	0	234	215	8.8
	Total	18	0	687	0	705	655	7.6

^a The total number of applicants to the Australian Orthopaedic SET program are included as single (1) applications only; it is unknown if these applicants also applied to other SET programs, therefore some applicants may be recorded more than once.

TABLE SET 4 – SET applications outcome by speciality and applicant type

Speciality	Offers		Unsuccessful		Waiting List		Withdrawn		Ineligible		Declined		Total application outcomes 2018
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
CAR	3	7	40	93	0	0	0	0	0	0	0	0	43
GEN	139	44.1	175	55.6	0	0	1	0.3	0	0	0	0	315
NEU	7	12.7	48	87.3	0	0	0	0	0	0	0	0	55
ORT	46	62.2	28	37.8	0	0	0	0	0	0	0	0	74
OTO	19	23.8	61	76.3	0	0	0	0	0	0	0	0	80
PAE	1	4.8	20	95.2	0	0	0	0	0	0	0	0	21
PLA	20	23	67	77	0	0	0	0	0	0	0	1	1.1
URO	20	33.3	40	66.7	0	0	0	0	0	0	0	3	5
VAS	7	18.4	31	81.6	0	0	0	0	0	0	0	3	7.9
Total	262	33.9	510	66	0	0	1	0.1	0	0	7	0.9	773

Applicant type														
SET	8	42.1	11	57.9	0	0	0	0	0	0	0	0	0	19
IMG	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non IMG / Trainee	254	33.7	499	66.2	0	0	1	0.1	0	0	7	0.9	754	
Total	262	33.9	510	66	0	0	1	0.1	0	0	7	0.9	773	

a Includes deferred applications

b Totals do not include declined applications as they were subsequently offered to other applicants and reflected in the Offers column.

TABLE SET 5 – Successful SET application by specialty and location of residence

Specialty & Location	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
CAR	Male	0	1	0	0	1	0	0	2	0	0	2	5	-60
	Female	0	0	0	1	0	0	0	1	0	0	1	3	-66.7
	Total	0	1	0	1	0	0	0	3	0	0	3	8	-62.5
GEN	Male	1	27	5	16	7	0	15	4	75	9	84	68	23.5
	Female	2	15	0	5	3	0	17	7	49	6	55	37	48.6
	Total	3	42	5	21	10	0	32	11	124	15	139	105	32.4
NEU	Male	0	1	0	2	0	2	1	6	0	0	6	3	100
	Female	0	0	0	1	0	0	0	1	0	0	1	5	-80
	Total	0	1	0	3	0	2	1	7	0	0	7	8	-12.5
ORT	Male	0	7	0	6	1	1	8	1	24	11	35	46	-23.9
	Female	0	1	0	2	1	0	1	2	7	4	11	10	10
	Total	0	8	0	8	2	1	9	3	31	15	46	56	-17.9
OTO	Male	0	2	0	2	1	0	3	1	9	3	12	19	-36.8
	Female	0	0	0	3	0	1	0	7	0	0	7	6	16.7
	Total	0	2	0	5	1	1	3	8	9	3	19	25	-24
PAE	Male	0	0	0	0	0	0	0	0	0	0	0	1	-100
	Female	0	0	0	1	0	0	0	1	0	0	1	3	-66.7
	Total	0	0	0	1	0	0	0	1	0	0	1	4	-75
PLA	Male	0	3	0	5	1	0	2	1	12	2	14	13	7.7
	Female	0	1	0	1	0	0	3	0	5	1	6	7	-14.3
	Total	0	4	0	6	1	0	5	1	17	3	20	20	0
URO	Male	0	5	0	1	1	0	2	3	12	2	14	19	-26.3
	Female	0	1	0	1	0	0	3	0	5	1	6	3	100
	Total	0	6	0	2	1	0	5	3	17	3	20	22	-9.1
VAS	Male	0	2	0	0	0	0	3	0	5	0	5	4	25
	Female	0	0	0	1	0	0	1	2	0	0	2	4	-50
	Total	0	2	0	1	0	0	3	1	7	0	7	8	-12.5
Total	Male	1	48	5	32	12	1	35	11	145	27	172	178	-3.4
	Female	2	18	0	16	7	0	25	10	78	12	90	78	15.4
	Total	3	66	5	48	19	1	60	21	223	39	262	256	2.3

TABLE SET 6 – Active SET Trainees by status and training location^a

Trainee status	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18	
Clinical	Male	11	255	6	131	53	11	184	64	715	117	2	854	835	-0.1
	Female	4	87	3	48	18	7	80	18	265	39	0	304	300	1.3
	Total	15	342	9	179	71	18	264	82	980	156	2	1138	1135	0.3
Accredited Research	Male	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Female	0	1	0	0	0	0	0	0	1	0	0	1	0	
	Total	0	1	0	0	0	0	0	0	1	0	0	1	0	
Part Time	Male	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Female	0	0	0	3	0	0	2	0	5	1	0	6	5	20
	Total	0	0	0	3	0	0	2	0	5	1	0	6	5	20
Probationary	Male	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Female	0	0	0	1	0	0	3	1	4	2	0	6	6	0
	Total	0	0	0	1	0	0	3	1	4	2	0	6	6	0
Exam Pending	Male	0	7	0	2	0	0	6	1	8	3	0	11	16	-31.3
	Female	0	2	0	0	0	0	0	0	9	0	0	9	11	-18.2
	Total	0	9	0	2	0	0	6	1	17	3	0	20	27	-33.3
Total	Male	11	262	6	133	53	11	187	65	728	119	2	849	852	-0.4
	Female	4	90	3	52	18	7	85	18	277	41	0	318	319	-0.3
	Total	15	352	9	185	71	18	272	83	1005	160	2	1167	1171	-0.3

^a Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET 7 – Active SET Trainees by status and training location^a

Location of Training by SET Status	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18	
Approved Interruption to training	Male	0	10	1	3	2	1	5	1	23	2	0	25	26	-3.8
	Female	0	18	0	6	1	1	8	5	39	12	0	51	37	37.8
	Total	0	28	1	9	3	2	13	6	62	14	0	76	63	20.6
Deferred	Male	0	3	0	2	3	1	1	0	10	2	0	12	8	50
	Female	0	0	0	0	0	0	0	0	1	0	0	1	0	
	Total	0	3	0	2	3	1	1	0	11	2	0	13	8	62.5
Suspended	Male	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Female	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Total	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	Male	0	13	1	5	5	2	6	1	33	4	0	37	34	8.8
	Female	0	18	0	6	2	1	8	5	40	16	0	56	42	33.3
	Total	0	31	1	11	7	3	14	6	73	20	0	93	76	22.4

^a Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET 8 – Active SET Trainees by status and speciality^a

Trainee Status	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL 2018	TOTAL 2017	% Change 17/18
Clinical	Male	25	285	40	235	16	62	78	33	834	835	-0.1
	Female	9	140	14	36	24	30	21	12	304	300	1.3
	Total	34	425	54	271	84	92	99	45	1138	1135	0.3
Accredited Research	Male	0	0	0	0	0	0	0	0	0	0	-
	Female	1	0	0	0	0	0	0	0	1	1	0
	Total	1	0	0	0	0	0	0	0	1	1	0
Part Time	Male	0	0	0	0	0	0	0	0	0	0	-
	Female	0	5	0	0	1	0	0	0	6	5	20
	Total	0	5	0	0	1	0	0	0	6	5	20
Probationary	Male	0	0	0	0	0	0	0	0	0	6	-100
	Female	0	0	0	0	0	1	0	0	1	10	-90
	Total	0	0	0	0	0	1	0	0	1	16	-93.8
Exam Pending	Male	3	9	0	1	0	2	0	0	15	11	36.4
	Female	0	4	0	2	0	0	0	0	6	3	100
	Total	3	13	0	3	0	2	0	0	21	14	50
Total	Male	28	294	40	236	60	64	78	33	849	852	-0.4
	Female	10	149	14	38	24	31	21	12	318	319	-0.3
	Total	38	443	54	274	84	95	99	45	1167	1171	-0.3

^a Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET 9 – Inactive SET Trainees by status and speciality^a

Trainee status	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL 2018	TOTAL 2017	% Change 17/18
Approved Interruption to training	Male	4	8	2	0	2	1	6	1	25	26	-3.8
	Female	0	32	1	1	6	2	4	1	51	37	37.8
	Total	4	40	3	1	8	3	5	10	76	63	20.6
Deferred	Male	0	4	0	0	4	0	2	1	12	8	50
	Female	0	2	0	0	1	0	1	0	4	4	0
	Total	0	6	0	0	5	0	3	1	16	12	33.3
Suspended	Male	0	0	0	0	0	0	0	0	0	0	-
	Female	0	1	0	0	0	0	0	0	1	1	0
	Total	0	1	0	0	0	0	0	0	1	1	0
Total	Male	4	12	2	0	6	1	3	7	37	34	8.8
	Female	0	35	1	1	7	2	5	4	56	42	33.3
	Total	4	47	3	1	13	3	8	11	93	76	22.4

^a Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET 10 – SET Trainees that exited the SET program, by speciality^a

Speciality	Terminated from SET		Withdrawn from SET		Other		Total	
	Male	Female	Male	Female	Male	Female	Male	Female
CAR	1	0	0	0	0	0	1	0
GEN	3	0	2	1	0	0	5	1
NEU	0	0	0	0	0	0	0	0
ORT	1	0	1	0	0	0	2	0
OTO	0	2	0	2	0	0	0	4
PAE	0	0	0	0	0	0	0	0
PLA	0	0	1	2	0	0	1	2
URO	1	0	2	0	0	0	3	0
VAS	0	0	0	0	0	0	0	0
Total	6	2	6	5	0	0	12	7
% of all trainees	0.7	0.6	1.9	1.5	0	0	3.6	2.2

^a Trainees that exited SET have not been counted as active Trainees in table SET.6 & 8.

TABLE SET 11 – SET Trainees that exited the SET program, by year of training^a

Speciality	Terminated from SET		Withdrawn from SET		Other		Total	
	Male	Female	Male	Female	Male	Female	Male	Female
Year 1	0	0	2	2	0	0	2	2
Year 2	0	1	1	0	0	0	1	1
Year 3	2	0	2	2	0	0	4	2
Year 4	0	0	0	0	0	0	0	0
Year 5	0	0	0	0	0	0	0	0
Year 6+	4	1	1	1	0	0	5	2
Total	6	2	6	5	0	0	12	7

^a Trainees that exited SET have not been counted as active Trainees in table SET.6 & 8.

TABLE SET 12 – SET Trainees that exited the SET program, by region^a

Speciality	Terminated from SET		Withdrawn from SET		Other		Total	
	Male	Female	Male	Female	Male	Female	Male	Female
ACT	0	0	0	0	0	0	0	0
NSW	3	2	1	0	0	0	4	2
NT	0	0	0	0	0	0	0	0
QLD	0	0	3	1	0	0	3	1
SA	2	0	0	0	0	0	2	0
TAS	0	0	0	0	0	0	0	0
VIC	1	0	2	2	0	0	3	2
WA	0	0	0	1	0	0	0	1
AUS	6	2	6	4	0	0	12	6
NZ	0	0	0	1	0	0	0	1
O/S	0	0	0	0	0	0	0	0
Total	6	2	6	5	0	0	12	7

^a Trainees that exited SET have not been counted as active Trainees in table SET.6 & 8.

TABLE SET 13 – Active SET Trainees by age and location of training post^a

Active Trainees by Speciality & Age	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018
<30	Male	0	25	0	8	1	9	3	51	8	1	60
	Female	0	13	1	2	0	7	0	24	1	0	25
	Total	0	38	1	9	1	16	3	75	9	1	85
30-34	Male	7	132	5	73	4	113	34	402	76	1	479
	Female	1	41	2	24	3	50	14	143	29	0	172
	Total	8	173	7	97	42	163	48	545	105	1	651
35-39	Male	4	72	1	41	6	46	22	203	27	0	230
	Female	3	28	0	26	7	4	22	93	8	0	101
	Total	7	100	1	67	18	10	68	296	35	0	331
40-44	Male	0	28	0	9	2	17	6	62	6	0	68
	Female	0	5	0	1	1	0	6	14	3	0	17
	Total	0	33	0	10	3	0	23	76	9	0	85
45-49	Male	0	3	0	2	1	0	2	8	2	0	10
	Female	0	3	0	0	0	0	0	3	0	0	3
	Total	0	6	0	2	1	0	2	11	2	0	13
50-54	Male	0	0	0	0	0	0	0	0	0	0	0
	Female	0	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0	0
55-70+	Male	0	2	0	0	0	0	0	2	0	0	2
	Female	0	0	0	0	0	0	0	0	0	0	0
	Total	0	2	0	0	0	0	0	2	0	0	2
Total	Male	11	262	6	133	53	187	65	728	119	2	849
	Female	4	90	3	52	18	85	18	277	41	0	318
	Total	15	352	9	185	71	272	83	1005	160	2	1167

^a Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET 14 – Active SET Trainees by age and speciality^a

Active Trainees by Speciality & Age	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL 2018
<30	Male	1	27	4	9	4	3	7	5	60
	Female	0	17	1	2	1	0	1	2	25
	Total	1	44	5	11	5	3	8	7	85
30-34	Male	18	151	24	137	34	11	37	48	479
	Female	7	65	9	28	11	11	21	13	172
	Total	25	216	33	165	45	22	58	61	651
35-39	Male	6	84	9	65	20	4	16	19	230
	Female	3	55	3	6	10	6	8	7	101
	Total	9	139	12	71	30	10	24	26	331
40-44	Male	1	30	3	22	1	7	2	1	68
	Female	0	9	1	2	2	1	2	0	17
	Total	1	39	4	24	3	2	9	2	85
45-49	Male	1	1	0	3	1	0	1	2	10
	Female	0	3	0	0	0	0	0	0	3
	Total	1	4	0	3	1	0	1	2	13
50-54	Male	0	0	0	0	0	0	0	0	0
	Female	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0
55-70+	Male	1	1	0	0	0	0	0	0	2
	Female	0	0	0	0	0	0	0	0	0
	Total	1	1	0	0	0	0	0	0	2
Total	Male	28	294	40	236	60	16	64	78	849
	Female	10	149	14	38	24	19	31	21	318
	Total	38	443	54	274	84	35	95	99	1167

^a Total data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET 15 – Active SET Trainees by years in training and training post location^a

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
Year 1														
Male	5	56	4	30	11	2	28	9	145	23	1	169	195	
Female	2	18	1	11	4	2	19	4	61	15	0	76	55	
Total	7	74	5	41	15	4	47	13	206	38	1	245	250	-2
Year 2														
Male	1	52	2	30	15	4	32	12	148	38	1	187	154	
Female	0	10	1	10	2	2	9	6	40	3	0	43	70	
Total	1	62	3	40	17	6	41	18	188	41	1	230	224	2.7
Year 3														
Male	1	44	0	25	10	0	37	13	130	21	0	151	135	
Female	1	18	0	3	3	1	21	2	49	10	0	59	43	
Total	2	62	0	28	13	1	58	15	179	31	0	210	178	18
Year 4														
Male	2	42	0	18	6	1	31	16	116	22	0	138	163	
Female	0	13	0	7	3	1	11	3	38	7	0	45	63	
Total	2	55	0	25	9	2	42	19	154	29	0	183	226	-19
Year 5														
Male	2	54	0	22	9	4	41	13	145	12	0	157	159	
Female	0	20	1	16	3	0	18	3	61	6	0	67	50	
Total	2	74	1	38	12	4	59	16	206	18	0	224	209	7.2
Year 6+														
Male	0	14	0	8	2	0	18	2	44	3	0	47	46	
Female	1	11	0	5	3	1	7	0	28	0	0	28	38	
Total	1	25	0	13	5	1	25	2	72	3	0	75	84	-10.7
Total	11	262	6	133	53	11	187	65	728	119	2	849	852	
Female	4	90	3	52	18	7	85	18	277	41	0	318	319	
Total	15	352	9	185	71	18	272	83	1005	160	2	1167	1171	-0.3

^aTotal data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET 16 – Active Cardiothoracic SET Trainees by years in training and training post location

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
Year 1														
Male	0	2	0	0	0	0	0	1	3	1	0	4	6	
Female	0	1	0	0	0	0	1	0	2	1	0	3	1	
Total	0	3	0	0	0	0	1	1	5	2	0	7	7	0
Year 2														
Male	0	1	0	0	1	0	1	0	3	1	0	4	6	
Female	0	0	0	0	0	0	0	0	0	0	0	0	2	
Total	0	1	0	0	1	0	1	0	3	1	0	4	8	-50
Year 3														
Male	0	1	0	2	1	0	0	1	5	1	0	6	4	
Female	0	1	0	0	0	0	1	0	2	0	0	2	2	
Total	0	2	0	2	1	0	1	1	7	1	0	8	6	33.3
Year 4														
Male	0	1	0	0	0	0	3	0	4	0	0	4	3	
Female	0	0	0	0	1	0	0	0	1	1	0	2	2	
Total	0	1	0	0	1	0	3	0	5	1	0	6	5	20
Year 5														
Male	0	1	0	0	0	1	1	0	3	2	0	5	10	
Female	0	1	0	0	0	0	1	0	2	0	0	2	1	
Total	0	2	0	0	0	1	2	0	5	2	0	7	11	-36.4
Year 6+														
Male	0	1	0	1	0	0	3	0	5	0	0	5	4	
Female	0	0	0	0	0	0	1	0	1	0	0	1	0	
Total	0	1	0	1	0	0	4	0	6	0	0	6	4	50
Total	0	7	0	3	2	1	8	2	23	5	0	28	33	
Female	0	3	0	0	1	0	4	0	8	2	0	10	8	
Total	0	10	0	3	3	1	12	2	31	7	0	38	41	-7.3

TABLE SET 16 – Active General Surgery SET Trainees by years in training and training post location

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 16/17
Year 1														
Male	1	18	4	12	2	1	14	2	54	7	1	62	67	
Female	1	10	1	5	0	1	7	1	26	6	0	32	31	
Total	2	28	5	17	2	2	21	3	80	13	1	94	98	-4.1
Year 2														
Male	1	18	1	11	5	0	12	5	53	13	1	67	40	
Female	0	8	1	4	1	0	7	0	21	2	0	23	36	
Total	1	26	2	15	6	0	19	5	74	15	1	90	76	18.4
Year 3														
Male	1	9	0	6	0	0	17	2	35	4	0	39	42	
Female	1	13	0	0	1	0	8	0	23	3	0	26	14	
Total	2	22	0	6	1	0	25	2	58	7	0	65	56	16.1
Year 4														
Male	2	12	0	7	1	0	8	6	36	8	0	44	69	
Female	0	8	0	3	1	0	4	0	16	1	0	17	38	
Total	2	20	0	10	2	0	12	6	52	9	0	61	107	-43
Year 5														
Male	0	22	0	10	4	3	16	7	62	6	0	68	46	
Female	0	12	1	8	3	0	9	2	35	3	0	38	25	
Total	0	34	1	18	7	3	25	9	97	9	0	106	71	49.3
Year 6+														
Male	0	8	0	3	0	0	2	1	14	0	0	14	15	
Female	1	5	0	2	2	1	2	0	13	0	0	13	11	
Total	1	13	0	5	2	1	4	1	27	0	0	27	26	3.8
Total	5	87	5	49	12	4	69	23	254	38	2	294	279	
Female	3	56	3	22	8	2	37	3	134	15	0	149	155	
Total	8	143	8	71	20	6	106	26	388	53	2	443	434	2.1

TABLE SET 18 – Active Neurosurgery SET Trainees by years in training and training post location

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
Year 1														
Male	0	1	0	1	0	0	0	0	2	1	0	3	10	
Female	1	1	0	2	1	0	1	0	6	0	0	6	0	
Total	1	2	0	3	1	0	1	0	8	1	0	9	10	-10
Year 2														
Male	0	5	0	1	1	1	2	1	11	0	0	11	10	
Female	0	0	0	0	0	0	0	0	0	0	0	0	1	
Total	0	5	0	1	1	1	2	1	11	0	0	11	11	0
Year 3														
Male	0	5	0	1	1	0	2	1	10	0	0	10	5	
Female	0	1	0	0	0	0	0	0	1	0	0	1	3	
Total	0	6	0	1	1	0	2	1	11	0	0	11	8	37.5
Year 4														
Male	0	2	0	1	0	0	3	0	6	0	0	6	6	
Female	0	1	0	0	0	0	1	0	2	0	0	2	2	
Total	0	3	0	1	0	0	4	0	8	0	0	8	8	0
Year 5														
Male	0	2	0	1	0	0	3	1	7	0	0	7	3	
Female	0	1	0	1	0	0	1	0	3	0	0	3	2	
Total	0	3	0	2	0	0	4	1	10	0	0	10	5	100
Year 6+														
Male	0	1	0	0	0	0	2	0	3	0	0	3	2	
Female	0	1	0	1	0	0	0	0	2	0	0	2	4	
Total	0	2	0	1	0	0	2	0	5	0	0	5	6	-16.7
Total														
Male	0	16	0	5	2	1	12	3	39	1	0	40	36	
Female	1	5	0	4	1	0	3	0	14	0	0	14	12	
Total	1	21	0	9	3	1	15	3	53	1	0	54	48	12.5

TABLE SET 19 – Active Orthopaedic SET Trainees by years in training and training post location^a

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
Year 1														
Male	0	15	0	10	4	0	7	2	38	8	0	46	55	
Female	0	2	0	0	2	0	3	1	8	2	0	10	3	
Total	0	17	0	10	6	0	10	3	46	10	0	56	58	-3.4
Year 2														
Male	0	14	0	12	3	2	10	4	45	10	0	55	47	
Female	0	1	0	0	1	0	0	1	3	0	0	3	12	
Total	0	15	0	12	4	2	10	5	48	10	0	58	59	-1.7
Year 3														
Male	0	13	0	8	4	0	8	6	39	7	0	46	58	
Female	0	1	0	1	1	0	6	0	9	2	0	11	7	
Total	0	14	0	9	5	0	14	6	48	9	0	57	65	-12.3
Year 4														
Male	0	22	0	8	3	1	10	7	51	7	0	58	39	
Female	0	3	0	0	1	1	2	0	7	1	0	8	4	
Total	0	25	0	8	4	2	12	7	58	8	0	66	43	53.5
Year 5														
Male	2	9	0	5	2	0	9	2	29	2	0	31	49	
Female	0	0	0	2	0	0	2	0	4	1	0	5	5	
Total	2	9	0	7	2	0	11	2	33	3	0	36	54	-33.3
Year 6+														
Male	0	0	0	0	0	0	0	0	0	0	0	0	2	
Female	0	0	0	0	0	0	1	0	1	0	0	1	2	
Total	0	0	0	0	0	0	1	0	1	0	0	1	4	-75
Total														
Male	2	73	0	43	16	3	44	21	202	34	0	236	250	
Female	0	7	0	3	5	1	14	2	32	6	0	38	33	
Total	2	80	0	46	21	4	58	23	234	40	0	274	283	-3.2

^aTotal data cannot be verified as Australian Orthopaedic Association do not routinely report individual Australian Orthopaedic trainee data to RACS.

TABLE SET 20 – Active Otolaryngology Head and Neck SET Trainees by years in training and training post location

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
Year 1														
Male	2	4	0	3	1	0	3	1	14	2	0	16	15	
Female	0	0	0	1	1	0	2	0	4	2	0	6	3	
Total	2	4	0	4	2	0	5	1	18	4	0	22	18	22.2
Year 2														
Male	0	5	0	2	1	0	0	1	9	3	0	12	8	
Female	0	0	0	2	0	0	0	0	2	0	0	2	3	
Total	0	5	0	4	1	0	0	1	11	3	0	14	11	27.3
Year 3														
Male	0	0	0	1	0	0	3	1	5	3	0	8	8	
Female	0	0	0	0	1	0	1	0	2	0	0	2	7	
Total	0	0	0	1	1	0	4	1	7	3	0	10	15	-33.3
Year 4+														
Male	0	2	0	1	1	0	1	0	5	3	0	8	14	
Female	0	1	0	1	0	0	0	2	4	2	0	6	6	
Total	0	3	0	2	1	0	1	2	9	5	0	14	20	-30
Year 5														
Male	0	7	0	3	0	0	2	1	13	0	0	13	11	
Female	0	1	0	2	0	0	2	1	6	1	0	7	4	
Total	0	8	0	5	0	0	4	2	19	1	0	20	15	33.3
Year 6+														
Male	0	0	0	0	0	0	3	0	3	0	0	3	2	
Female	0	0	0	0	1	0	0	0	1	0	0	1	5	
Total	0	0	0	0	1	0	3	0	4	0	0	4	7	-42.9
Total														
Male	2	18	0	10	3	0	12	4	49	11	0	60	58	
Female	0	2	0	6	3	0	5	3	19	5	0	24	28	
Total	2	20	0	16	6	0	17	7	68	16	0	84	86	-2.3

TABLE SET 21 – Active Paediatric SET Trainees by years in training and training post location

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
Year 1														
Male	1	0	0	0	0	0	0	0	1	0	0	1	5	
Female	0	1	0	1	0	0	0	1	3	0	0	3	3	
Total	1	1	0	1	0	0	0	1	4	0	0	4	8	
Year 2														
Male	0	0	1	0	1	0	0	0	2	2	0	4	2	
Female	0	0	0	2	0	1	0	0	3	0	0	3	5	
Total	0	0	1	2	1	1	0	0	5	2	0	7	7	0
Year 3														
Male	0	0	0	2	0	0	0	1	3	0	0	3	3	
Female	0	1	0	0	0	1	1	3	2	0	0	5	2	
Total	0	1	0	2	0	1	2	6	2	0	0	8	5	60
Year 4														
Male	0	0	0	0	1	0	0	0	1	2	0	3	1	
Female	0	0	0	1	0	0	0	1	2	0	0	2	1	
Total	0	0	0	1	1	0	0	1	3	2	0	5	2	150
Year 5														
Male	0	0	0	0	0	0	2	0	2	0	0	2	3	
Female	0	1	0	1	0	0	1	0	3	0	0	3	1	
Total	0	1	0	1	0	0	3	0	5	0	0	5	4	25
Year 6+														
Male	0	0	0	0	0	0	2	0	2	1	0			

TABLE SET 22 – Active Plastic and Reconstructive SET Trainees by years in training and training post location

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
Year 1														
Male	0	10	0	2	1	0	3	2	18	2	0	20	15	
Female	0	1	0	1	0	0	2	0	4	1	0	5	5	
Total	0	11	0	3	1	0	5	2	22	3	0	25	20	25
Year 2														
Male	0	4	0	3	1	0	3	0	11	3	0	14	19	
Female	0	0	0	0	0	1	1	0	2	1	0	3	2	
Total	0	4	0	3	1	1	4	0	13	4	0	17	21	-19
Year 3														
Male	0	6	0	3	1	0	2	1	13	4	0	17	1	
Female	0	0	0	0	0	0	1	1	2	0	0	2	2	
Total	0	6	0	3	1	0	3	2	15	4	0	19	3	533.3
Year 4														
Male	0	0	0	1	0	0	0	0	1	0	0	1	11	
Female	0	0	0	0	0	2	0	2	0	0	0	2	4	
Total	0	0	0	1	0	2	0	3	0	0	0	3	15	-80
Year 5														
Male	0	5	0	1	1	0	3	0	10	1	0	11	15	
Female	0	2	0	0	0	0	1	0	3	0	0	3	5	
Total	0	7	0	1	1	0	4	0	13	1	0	14	20	-30
Year 6+														
Male	0	4	0	4	1	0	5	1	15	0	0	15	16	
Female	0	3	0	1	0	0	2	0	6	0	0	6	7	
Total	0	7	0	5	1	0	7	1	21	0	0	21	23	-8.7
Total														
Male	0	29	0	14	5	0	16	4	68	10	0	78	77	
Female	0	6	0	2	0	1	9	1	19	2	0	21	25	
Total	0	35	0	16	5	1	25	5	87	12	0	99	102	-2.9

TABLE SET 23 – Active Urology SET Trainees by years in training and training post location

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
Year 1														
Male	0	10	0	2	1	0	3	2	18	2	0	20	15	
Female	0	1	0	1	0	0	2	0	4	1	0	5	5	
Total	0	11	0	3	1	0	5	2	22	3	0	25	20	25
Year 2														
Male	0	4	0	3	1	0	3	0	11	3	0	14	19	
Female	0	0	0	0	0	1	1	0	2	1	0	3	2	
Total	0	4	0	3	1	1	4	0	13	4	0	17	21	-19
Year 3														
Male	0	6	0	3	1	0	2	1	13	4	0	17	1	
Female	0	0	0	0	0	0	1	1	2	0	0	2	2	
Total	0	6	0	3	1	0	3	2	15	4	0	19	3	533.3
Year 4														
Male	0	0	0	1	0	0	0	0	1	0	0	1	11	
Female	0	0	0	0	0	0	2	0	2	0	0	2	4	
Total	0	0	0	1	0	0	2	0	3	0	0	3	15	-80
Year 5														
Male	0	5	0	1	1	0	3	0	10	1	0	11	15	
Female	0	2	0	0	0	0	1	0	3	0	0	3	5	
Total	0	7	0	1	1	0	4	0	13	1	0	14	20	-30
Year 6+														
Male	0	4	0	4	1	0	5	1	15	0	0	15	16	
Female	0	3	0	1	0	0	2	0	6	0	0	6	7	
Total	0	7	0	5	1	0	7	1	21	0	0	21	23	-8.7
Total														
Male	0	29	0	14	5	0	16	4	68	10	0	78	77	
Female	0	6	0	2	0	1	9	1	19	2	0	21	25	
Total	0	35	0	16	5	1	25	5	87	12	0	99	102	-2.9

TABLE SET 24 – Active Vascular Surgery SET Trainees by years in training and training post location

Location & Year of Training	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18
Year 1														
Male	1	2	0	0	1	0	0	0	4	1	0	5	7	
Female	0	0	0	1	0	0	2	0	3	1	0	4	2	
Total	1	2	0	1	1	0	2	0	7	2	0	9	9	0
Year 2														
Male	0	2	0	1	0	0	1	0	4	2	0	6	7	
Female	0	0	0	1	0	0	0	1	2	0	0	2	3	
Total	0	2	0	2	0	0	1	1	6	2	0	8	10	-20
Year 3														
Male	0	4	0	0	0	0	2	0	6	1	0	7	4	
Female	0	1	0	1	0	0	1	0	3	0	0	3	3	
Total	0	5	0	1	0	0	3	0	9	1	0	10	7	42.9
Year 4														
Male	0	2	0	0	0	0	1	1	4	0	0	4	12	
Female	0	0	0	1	0	0	1	0	2	0	0	2	1	
Total	0	2	0	1	0	0	2	1	6	0	0	6	13	-53.8
Year 5														
Male	0	5	0	1	2	0	2	0	10	0	0	10	4	
Female	0	0	0	0	0	0	1	0	1	0	0	1	1	
Total	0	5	0	1	2	0	3	0	11	0	0	11	5	120
Year 6+														
Male	0	0	0	0	0	0	0	0	0	0	0	0	1	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total	0	0	0	0	0	0	0	0	0	0	0	0	1	
Total														
Male	1	15	0	2	3	0	6	1	28	5	0	33	36	
Female	0	1	0	4	0	0	5	1	11	1	0	12	11	
Total	1	16	0	6	3	0	11	2	39	6	0	45	47	-4.3

SECTION FOUR

EXAMINATIONS

EXPLANATORY NOTES

Surgical Science Examinations – Generic and Specialty Specific

The Generic Surgical Science Examination (GSSE) comprises two components and is mandatory for all specialties. Numbers reflected in these reports are representative of all examination sittings held in Australia and New Zealand in 2018 (including all attempts). As passing the GSSE is now a requirement prior to applying to the SET program for all specialties, the number of new SET Trainees that have already passed the GSSE prior to commencing SET training is increasing. Conversely, the number of existing SET Trainees who will sit for the GSSE has decreased. The name change to Table EXAM.1 to include the term 'SET Trainees' highlights this change. The GSSE was conducted three times in 2018 for prevocational doctors and twice for SET Trainees.

All specialty specific examinations are presented in the one table and indicate all sittings and all attempts (Table EXAM.2). Held concurrently with the GSSE, the Specialty Specific Examination is conducted for Otolaryngology Head and Neck Surgery, Urology and Vascular Surgery. For trainees commencing from 2014, the Board in General Surgery replaced the Specialty Specific Examination in General Surgery with Surgical Education and Assessment Modules (SEAM); SEAM is not reported by RACS. For trainees commencing from 2016, the Board of Neurosurgery removed the specialty specific examination as a requirement. The remaining specialty specific examinations are the Cardiothoracic Surgical Science and Principles (CSSP), Orthopaedic Principles and Basic Sciences (OPBS), Plastic and Reconstructive Surgical Sciences and Principles (PRSSP) and the Paediatric Anatomy and Embryology (PAE) and Paediatric Pathology and Pathophysiology (PPP) Examinations.

Clinical Examination

The Clinical Examination consists of 16 Objective Structured Clinical Examinations (OSCE) stations. Numbers reflected in the Clinical Examination report are representative of the exams held in Australia and New Zealand for all sittings and all attempts. For trainees commencing from 2016, the Board of Neurosurgery removed the Clinical Examination as a requirement. For trainees

commencing from 2018 onwards, General Surgery, Orthopaedic Surgery (Australia) and Otolaryngology Head & Neck Surgery (OHNS) removed the Clinical Examination as a requirement. For trainees who commence training in 2019 onwards, Orthopaedic Surgery (New Zealand) removed the Clinical Examination as a requirement.

Fellowship Examinations

Numbers reflected in the Fellowship Examination reports are representative of the exams held in Australia and New Zealand in May and September 2018 and reported with respect to:

- > Individual sitting and annual pass rate
 - > Eventual pass rate by specialty (compares the number of candidates successfully completing the Fellowship Examinations within a 5-year period since first attempt; includes SET Trainees and IMGs)
 - > Annual Fellowship Examination pass rate by state and specialty
 - SET Trainees
 - International Medical Graduates
 - > Cumulative attempts to pass the Fellowship Examination (all candidates presenting in 2018 and the number of attempts).
- Note that previous reporting of this table has always included cumulative attempts for both SET and IMGs, and we have changed the title of this table to reflect this.

Data reporting in Tables EXAM.6 and EXAM.7

Tables EXAM.6 and EXAM.7 report annual pass rates. The annual pass rate reports on the overall success of the candidate passing Fellowship Examination within the calendar year. Previous years Activities Reports have reported the individual pass rate attempts.

EXAM.8 reports the number of female and male candidates who present for the Fellowship Examinations. The numbers represented include SET trainees and IMGs who sat and passed the FEX within the calendar year by specialty. Activities Reports from earlier years did not report this information.

DATA HIGHLIGHTS

Generic and Specialty Specific Surgical Science Examinations

The number of SET Trainees sitting the GSSE has decreased sharply from 2016, reflecting the policy change that requires prevocational doctors to pass the exam prior to applying to the SET program. The number of prevocational doctors presenting for the GSSE has decreased by 5.76% from 1041 in 2017 to 981 in 2018. The pass rate has also decreased as compared to 2017. The cumulative pass rate for the prevocational doctor cohort decreased from 61.2% in 2017 to 60.3% in 2018 (Table EXAM.10).

The number of candidates and pass rate in the Specialty Specific Surgical Science Examinations decreased. The 78.2% pass rate in was a decrease from 84.8% pass rate in 2017 and the number of trainees decreased slightly in 2018 compared to 2017.

Clinical Examination

The pass rate for the Clinical Examination was 68.4%, a decrease of 10.9%. Neurosurgery, General Surgery, Orthopaedic Surgery (Australia) and Otolaryngology Head & Neck Surgery Trainees are not required to present for the Clinical Examination. As a result, the number of candidates decreased by 17%.

Fellowship Examination

The overall pass rate for the Fellowship Examination has increased to 65.8% from 6.3% in 2017. There was also an increase in the total numbers of 13% for both SET Trainees and IMGs sitting for the exam compared to 2017. The overall pass rate for SET Trainees continues to vary between specialties (Table EXAM.6).

The eventual Fellowship Examination pass rate for SET Trainees and IMGs continues to be consistent across the last four Trainee cohorts, with the last two cohorts reporting an eventual pass rate of more than 98% (Table EXAM.5). The eventual pass rate of the IMG cohort remains at a comparable level compared to the SET cohort.

The number of female candidates sitting for the Fellowship Examination decreased from 93 candidates in 2017 to 89 candidates in 2018. The number of male candidates increased from 234 in 2017 to 288 in 2018. By gender, the pass rate for female candidates increased by 6.5% and for male candidates increased by 1.5% (Table EXAM.8).

Compared to 2017, the annual pass rate for first attempt remained similar and increased for second and third attempts. The numbers take into consideration both SET Trainees and IMGs. Overall, for General Surgery the first attempt pass rate decreased from 67% in 2017 to 60% in 2018 and second attempt pass rate increased from 64% in 2017 to 69.2% in 2018. For Urology the pass rates for first and second attempts increased resulting in a decrease of third attempts. First attempt pass rates were higher in 2018 as compared to 2017 for Otolaryngology Head and Neck Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery (Table EXAM.9).

RACS continues to monitor examination pass rates and identify areas for ongoing improvement.

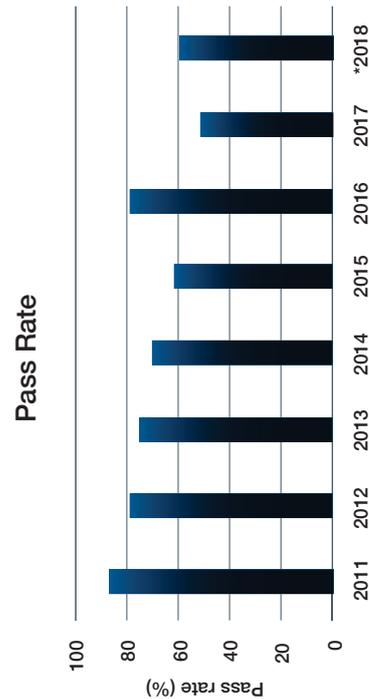
TABLE EXAM 1 – SET Trainee pass rate of individual attempts (total sittings) at Generic Surgical Science Examination by specialty and location

Note: Where location is specified, the State and/or Country reflected in these reports refer to the candidate's mailing address. This is not necessarily the location where the candidate has undertaken all of their training, oversight and/or examinations.

Location, Specialty & Outcomes	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	TOTAL 2018
CAR	Sat	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	0	0	0	0	0	0	0
GEN	Sat	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	0	0	0	0	0	0	0
NEU	Sat	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	0	0	0	0	0	0	0
ORT	Sat	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	2	0	2	2	0	0	2
OTO	Sat	0	1	0	0	0	0	0	1	0	0	1
	Pass	0	1	0	0	0	0	0	1	0	0	1
PAE	Sat	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	0	0	0	0	0	0	0
PLA	Sat	0	0	0	0	0	0	4	4	0	0	4
	Pass	0	0	0	0	0	0	3	3	0	0	3
URO	Sat	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	0	0	0	0	0	0	0
VAS	Sat	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	0	0	0	0	0	0	0
Total Sitting	Sat	0	1	0	0	0	2	4	7	0	0	7
	Pass	0	1	0	0	0	1	3	5	0	0	5
	%Pass	-	100	-	-	-	50	75	71.4	-	-	71.4

Note: Sat numbers are based on unique candidates; that is, candidates who sat multiple times for examinations are only counted once.

FIGURE EXAM 1 – Overall annual pass rate of individual attempts (total sittings) at Generic Surgical Science Examination (2011-2018)



*2018 pass rate based on non_SET attempts to pass the GSSE. Previous years is the pass rate for SET trainees.

TABLE EXAM 2 – Pass rate of individual attempts (total sittings) at Specialty Specific Surgical Science Examination by specialty and location

Location, Specialty & Outcomes	Location, Specialty & Outcomes												TOTAL 2018
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S		
CAR	Sat	0	2	0	2	0	0	5	0	9	1	0	10
	Pass	0	0	0	0	0	0	1	0	1	0	0	1
GEN	Sat	0	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	0	0	0	0	0	0	0	0
NEU	Sat	0	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	0	0	0	0	0	0	0	0
ORT (OPBS)	Sat	0	27	0	14	9	0	18	10	78	9	0	87
	Pass	0	23	0	11	6	0	11	7	58	9	0	67
OTO	Sat	0	7	0	4	3	0	5	3	22	4	0	26
	Pass	0	6	0	4	3	0	5	3	21	3	0	24
PAE (ANAT)	Sat	0	2	0	4	0	1	0	1	8	3	0	11
	Pass	0	1	0	2	0	0	0	0	3	2	0	5
PAE (PATH)	Sat	0	0	0	0	0	0	0	0	0	0	0	0
	Pass	0	0	0	0	0	0	0	0	0	0	0	0
PLA	Sat	0	7	0	3	1	0	2	4	17	4	0	21
	Pass	0	6	0	3	1	0	2	3	15	3	0	18
URO	Sat	0	4	0	1	1	1	6	0	13	4	0	17
	Pass	0	4	0	1	1	1	6	0	13	4	0	17
VAS	Sat	0	3	0	1	0	0	2	1	7	1	0	8
	Pass	0	3	0	1	0	0	2	1	7	1	0	8
Total Sitting	Sat	0	52	0	29	14	2	38	19	154	26	0	180
	Pass	0	43	0	22	11	1	27	14	118	22	0	140
	%Pass	0	82.7	0	75.9	78.6	50	71.1	73.7	76.6	84.6	0	77.8

Note: Sat numbers are based on unique candidates; that is, candidates who sat multiple times for examinations are only counted once.
*The Paediatric Pathology Exam changed format in 2018 and not candidate was eligible to present at the time.

FIGURE EXAM 2 – Overall annual pass rate of individual attempts (total sittings) at Specialty Specific Surgical Science Examination (2011-2018)

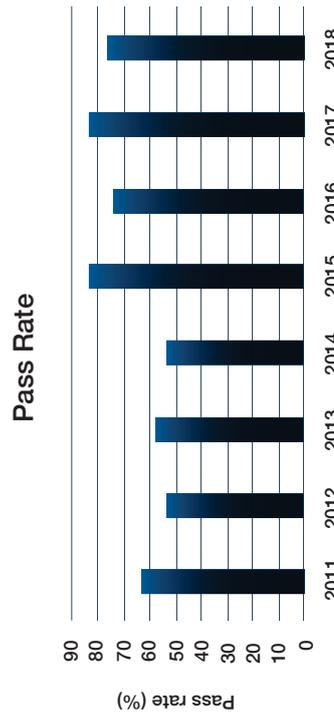


TABLE EXAM 3 – Pass rate of individual attempts (total sittings) at Clinical Examination by speciality and location

Location, Speciality & Outcomes	ACT		NSW		NT		QLD		SA		TAS		VIC		WA		AUS		NZ		O/S		TOTAL 2018		% Pass		
	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	Sat	Pass	
CAR	0	5	0	0	0	0	2	0	5	0	5	0	12	1	0	13	53.8										
GEN	3	40	1	20	4	0	28	8	104	22	1	127	72.4														
NEU	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ORT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OTO	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PAE	1	1	0	1	0	0	1	1	5	2	0	7	85.7														
PLA	0	3	0	4	0	2	6	19	4	0	23	78.3															
URO	0	10	0	2	1	0	5	1	19	5	0	24	56.3														
VAS	0	5	0	1	0	0	5	0	11	2	0	14	61.5														
Total Sitting	4	64	1	30	14	1	42	16	172	55	1	228	68.4														
% Pass	3	39	1	21	9	1	38	11	123	31	1	156	68.4														
% Pass	75	60.9	100	70	64.3	100	90.5	68.8	71.5	56.4	100	68.4															

FIGURE EXAM 3 – Overall annual pass rate of individual attempts (total sittings) at Clinical Examination (2011-2018)

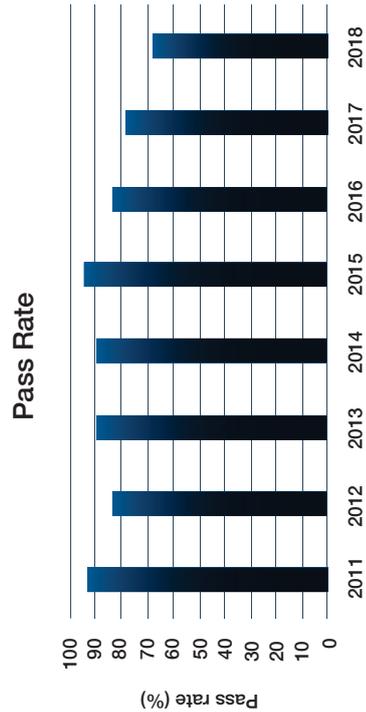


TABLE EXAM 4 – Pass rate of individual attempts (total sittings) at Specialty Specific Surgical Science Examination by speciality and location

	April			August			Total individual attempts & pass rate ^a						Annual pass rate ^b		
	Sat	Pass	%	Sat	Pass	%	Sat	Pass	%	Sat	Pass	%	Sat	Pass	%
CAR	8	3	37.5	9	4	44.4	17	7	41.2	12	7	58.3			
GEN	111	64	57.7	55	36	65.5	166	100	60.2	126	100	79.4			
NEU	7	7	100	0	0	-	7	7	100	7	7	100			
ORT	50	34	68	26	19	73.1	76	53	69.7	65	53	81.5			
OTO	24	18	75	9	7	77.8	33	25	75.8	28	25	89.3			
PAE	3	2	66.7	1	0	0	4	2	50	4	2	50			
PLA	18	15	83.3	12	8	66.7	30	23	76.7	27	23	85.2			
URO	13	8	61.5	14	9	64.3	27	17	63	23	17	73.9			
VAS	12	10	83.3	5	4	80	17	14	82.4	15	14	93.3			
Total	246	161	65.4	131	87	66.4	377	248	65.8	307	248	80.8			

^a Total sittings: records numbers of candidates; some candidates sit twice during a year.
^b Annual pass rate reports on the success rate of the individual candidates (over 1 or 2 sittings) passing Fellowship Exam in 2018.

TABLE EXAM 5 – Eventual Fellowship Examination pass rate by speciality

	2010		2015		2016		2017		2018		2019		2020		2021		2022		2023		2024		2025		2026		2027		2028		2029		2030	
	Initially Sat	Eventual Pass																																
CAR	15	14	93.3	2	2	100	7	7	100	4	3	75																						
GEN	59	57	96.6	85	84	98.8	86	83	96.5	61	60	98.4																						
NEU	8	6	75	7	5	71.4	7	6	85.7	6	6	100																						
ORT	61	60	98.4	55	54	98.2	54	52	96.3	38	38	100																						
OTO	7	7	100	5	5	100	6	6	100	2	2	100																						
PAE	4	4	100	4	4	100	3	3	100	3	3	100																						
PLA	21	19	90.5	26	26	100	13	13	100	17	17	100																						
URO	20	19	95	19	19	100	22	22	100	17	17	100																						
VAS	9	9	100	9	9	100	8	8	100	5	5	100																						
TOTAL	218	209	95.9	220	218	99.1	223	218	97.8	184	184	100																						
% Pass	32	29	90.6	21	18	85.7	23	20	87	22	22	100																						

TABLE EXAM 6 – Fellowship Examinations pass rate (per sitting) of SET Trainees by location and speciality

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018
CAR	Sat	0	5	0	1	0	9	0	16	0	0	16
	Pass	0	1	0	1	0	4	0	7	0	0	7
GEN	Sat	2	55	0	28	2	35	13	142	12	1	155
	Pass	0	31	0	17	0	26	7	86	9	0	95
NEU	Sat	0	2	0	1	0	2	0	6	0	0	6
	Pass	0	2	0	1	0	2	0	6	0	0	6
ORT	Sat	1	14	0	6	0	17	2	42	11	0	53
	Pass	0	13	0	6	0	13	1	34	10	0	44
OTO	Sat	0	6	0	5	0	8	2	23	7	0	30
	Pass	0	6	0	4	0	7	2	21	4	0	25
PAE	Sat	0	1	0	0	0	2	0	3	1	0	4
	Pass	0	1	0	0	0	1	0	2	0	0	2
PLA	Sat	0	9	0	3	1	4	4	21	3	0	24
	Pass	0	8	0	3	1	3	2	17	2	0	19
URO	Sat	1	3	0	6	2	9	2	23	2	0	25
	Pass	0	2	0	3	1	5	2	13	2	0	15
VAS	Sat	2	7	0	0	1	4	0	14	3	0	17
	Pass	2	5	0	0	1	4	0	12	2	0	14
Total Sitting	Sat	6	102	0	50	17	90	23	290	39	1	330
	Pass	2	69	0	35	13	65	14	198	29	0	227
	%Pass	33.3	67.6	-	70	76.5	72.2	60.9	68.3	74.4	0	68.8

TABLE EXAM 7 – Fellowship Examinations pass rate (per sitting) of International Medical Graduates by location and speciality

Location, Speciality & Outcomes	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	% Pass
CAR	Sat	0	1	0	0	0	0	0	1	0	0	1	
	Pass	0	0	0	0	0	0	0	0	0	0	0	0
GEN	Sat	0	4	2	0	1	0	2	11	0	0	11	
	Pass	0	1	1	0	1	0	1	5	0	0	5	45.5
NEU	Sat	0	0	0	0	0	1	0	1	0	0	1	
	Pass	0	0	0	0	0	1	0	1	0	0	1	100
ORT	Sat	0	5	0	7	3	1	7	23	0	0	23	
	Pass	0	2	0	2	1	4	0	9	0	0	9	39.1
OTO	Sat	0	0	0	0	0	3	0	3	0	0	3	
	Pass	0	0	0	0	0	0	0	0	0	0	0	0
PAE	Sat	0	0	0	0	0	0	0	0	0	0	0	
	Pass	0	0	0	0	0	0	0	0	0	0	0	-
PLA	Sat	1	2	0	0	2	0	1	6	0	0	6	
	Pass	1	1	0	0	1	0	1	4	0	0	4	66.7
URO	Sat	0	0	1	0	0	1	0	2	0	0	2	
	Pass	0	0	1	0	0	1	0	2	0	0	2	100
VAS	Sat	0	0	0	0	0	0	0	0	0	0	0	
	Pass	0	0	0	0	0	0	0	0	0	0	0	-
Total Sitting	Sat	1	12	2	8	4	3	14	3	47	0	47	
	Pass	1	4	1	3	2	7	2	21	0	0	21	44.7
	% Pass	100	33.3	50	12.5	75	66.7	50	66.7	44.7	-	44.7	

TABLE EXAM 8 – Fellowship Examinations pass rate (per sitting) of SET and IMG by gender and speciality

	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	TOTAL 2018	% pass
Female	Sat	3	50	2	4	8	3	10	5	89	71.9
	Pass	2	33	2	4	7	1	8	4	64	
Male	Sat	14	116	5	72	25	1	20	22	288	63.9
	Pass	5	67	5	49	18	1	15	13	184	
Total	Sat	17	166	7	76	33	4	30	27	377	65.8
	Pass	7	100	7	53	25	2	23	17	248	
	% Pass	41.2	60.2	100	69.7	75.8	50	76.7	63	82.4	

TABLE EXAM 9 – SET Trainees and IMGs cumulative attempts to pass Fellowship Examination by specialty for candidates presenting in 2018

Attempt	CAR	GEN	NEU	ORT	OTO	PAE	PLA	UFO	VAS	TOTAL 2018	TOTAL 2017
1	Sat 8	110	7	56	24	2	21	16	11	255	226
	Pass 4	66	7	41	20	1	16	12	10	177	158
	% Pass 50	60	100	73.2	83.3	50	76.2	75	90.9	69.4	69.9
2	Sat 3	39	0	11	4	0	4	7	3	71	59
	Pass 2	27	0	7	3	0	4	2	2	47	34
	% Pass 66.7	69.2	-	63.6	75	-	100	28.6	66.7	66.2	57.6
3	Sat 1	3	0	4	3	1	2	4	2	27	19
	Pass 3	8	0	3	1	1	2	3	1	15	7
	% Pass 33.3	37.5	-	75	33.3	100	100	75	50	55.6	36.8
4	Sat 2	5	0	2	2	0	1	0	1	13	12
	Pass 0	3	0	0	1	0	0	0	1	5	4
	% Pass 0	60	-	0	50	-	0	-	100	38.5	33.3
5	Sat 0	1	0	2	0	0	2	0	0	5	6
	Pass 0	0	0	2	0	0	1	0	0	3	2
	% Pass 0	-	-	100	-	-	50	-	-	60	33
6	Sat 1	2	0	1	0	1	0	0	0	5	3
	Pass 0	0	0	0	0	0	0	0	0	0	1
	% Pass -	0	-	0	-	0	-	-	-	0	33.3
7	Sat 0	1	0	0	0	0	0	0	0	1	1
	Pass 0	1	0	0	0	0	0	0	0	1	1
	% Pass -	100	-	-	-	-	-	-	-	100	100
8	Sat 0	0	0	0	0	0	0	0	0	0	1
	Pass 0	0	0	0	0	0	0	0	0	0	0
	% Pass -	-	-	-	-	-	-	-	-	-	0
Total	Sat 17	166	7	76	33	4	30	27	17	377	327
	Pass 7	100	7	53	25	2	23	17	14	248	207
	% Pass 41.2	60.2	100	69.7	75.8	50	76.7	63	82.4	65.8	63.3

FIGURE EXAM 4 – Overall Fellowship Examination pass rate of SET Trainees and IMGs (2010-2018)

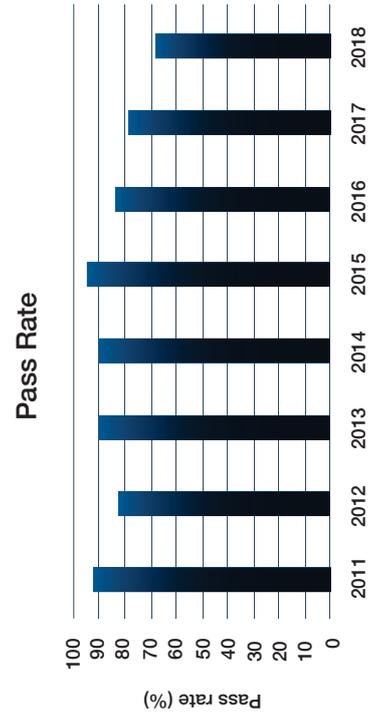


TABLE EXAM 10 – Non-SET cumulative attempts to pass Generic Surgical Science Examination by location

Attempt No.	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS Total	NZ	O/S	Total
1	Sat 8	176	0	120	40	5	148	60	557	97	0	654
	Pass 7	117	0	92	24	3	109	40	392	78	0	470
	% pass 87.5	66.5	-	76.7	60	60	73.6	66.7	70.4	80.4	-	71.9
2	Sat 0	42	1	25	14	4	29	13	128	15	0	143
	Pass 0	24	0	10	9	1	13	5	62	7	0	69
	% pass -	57.1	0	40	64.3	25	44.8	38.5	48.4	46.7	-	48.3
3	Sat 0	23	0	12	4	2	16	11	68	5	0	73
	Pass 0	5	0	4	1	1	5	5	21	3	0	24
	% pass -	21.7	-	33.3	25	50	31.3	45.5	30.9	60	-	32.9
4	Sat 1	20	0	2	4	0	8	3	38	5	0	43
	Pass 0	5	0	0	0	0	1	1	7	1	0	8
	% pass 0	25	-	0	0	-	12.5	33.3	18.4	20	-	18.6
5	Sat 3	19	1	4	1	0	9	2	39	3	0	42
	Pass 0	7	0	0	1	0	4	0	12	1	0	13
	% pass 0	36.8	0	0	100	-	44.4	0	30.8	33.3	-	31
6	Sat 1	10	0	0	1	0	4	1	17	1	0	18
	Pass 0	1	0	0	1	0	2	1	5	1	0	6
	% pass 0	10	-	-	100	-	50	100	29.4	100	-	33.3
7	Sat 0	4	0	0	0	0	0	0	4	0	0	4
	Pass 0	1	0	0	0	0	0	0	1	0	0	1
	% pass -	25	-	-	-	-	-	-	25	-	-	25
8	Sat 0	1	0	0	0	0	0	0	1	0	0	1
	Pass 0	0	0	0	0	0	0	0	0	0	0	0
	% pass -	0	-	-	-	-	-	-	0	-	-	0
9	Sat 0	0	0	1	0	0	0	0	1	0	0	1
	Pass 0	0	0	0	0	0	0	0	0	0	0	0
	% pass -	-	-	0	-	-	-	-	0	-	-	0
10	Sat 0	0	0	1	0	0	0	0	1	0	0	1
	Pass 0	0	0	0	0	0	0	0	0	0	0	0
	% pass -	-	-	0	-	-	-	-	0	-	-	0
11	Sat 0	0	0	1	0	0	0	0	1	0	0	1
	Pass 0	0	0	1	0	0	0	0	1	0	0	1
	% pass -	-	-	100	-	-	-	-	100	-	-	100
TOTAL	Sat 13	295	2	166	64	11	214	90	855	126	0	981
	Pass 7	160	0	107	36	5	134	52	501	91	0	592
	% pass 53.8	54.2	0	64.5	56.3	45.5	62.6	57.3	58.6	72.2	-	60.3

SECTION FIVE

WORKFORCE DISTRIBUTION

EXPLANATORY NOTES

In all tables the last known address is used when the current address is unknown. Region is based on mailing postcode and country. An active Fellow is involved in medicine, surgery, medico-legal work or other specialist non-procedural and non-clinical work such as surgical administration and academia.

EXPLANATORY NOTES

In 2018, there were 7572 Fellows across Australia, New Zealand and overseas (Table WFD.1). Of these 5258 were active Fellows in Australia and 839 were active Fellows in New Zealand (Table WFD.2).

The number of admissions to RACS Fellowship was slightly lower in 2018 compared to the previous year, with 223 SET Trainees and International Medical Graduates obtaining Fellowship (Table WFD.11). Just over 26% of surgeons who achieved Fellowship through the SET pathway were female (Table WFD.9), while just

over 9% of IMGs who obtained Fellowship were female (Table WFD.10). Female surgeons make up just over 13% of active surgical workforce, with the number of female surgeons in active practice increasing by 6% in the last year (Table WFD.3).

The proportion of surgeons located in rural or regional areas remains steady. The specialities of General surgery (21%), Orthopaedic surgery (17%) and Urology (16%) have the largest proportion of Fellows working in rural and remote areas of Australia (Table WFD.6).

TABLE WFD 1 – Active and retired RACS Fellows by location and speciality

Location & Speciality	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	Total 2018	Total 2017	% Change 17/18	
CAR	Male	6	65	0	42	14	5	62	18	212	34	30	276	276	0
	Female	0	5	0	2	0	0	6	1	14	3	0	17	17	0
	Total	6	70	0	44	14	5	68	19	226	37	30	293	293	0
GEN	Male	23	649	17	344	165	30	500	158	1886	279	167	2332	2313	0.8
	Female	5	100	2	57	27	5	92	27	315	44	24	383	361	6.1
	Total	28	749	19	401	192	35	592	185	2201	323	191	2715	2674	1.5
NEU	Male	7	80	0	49	17	8	61	21	243	23	31	297	297	0
	Female	1	11	0	8	6	1	8	1	36	1	1	38	34	11.8
	Total	8	91	0	57	23	9	69	22	279	24	32	335	331	1.2
ORT	Male	22	466	4	314	129	25	322	143	1425	295	68	1788	1744	2.5
	Female	3	17	0	12	6	0	17	3	58	16	2	76	73	4.1
	Total	25	483	4	326	135	25	339	146	1483	311	70	1864	1817	2.6
OTO	Male	13	155	3	99	47	7	113	43	480	86	28	594	587	1.2
	Female	0	24	0	12	5	2	24	4	71	19	4	94	89	5.6
	Total	13	179	3	111	52	9	137	47	551	105	32	688	676	1.8
PAE	Male	3	32	0	15	5	2	28	7	92	17	26	135	135	0
	Female	1	11	0	4	4	1	7	3	31	4	7	42	41	2.4
	Total	4	43	0	19	9	3	35	10	123	21	33	177	176	0.6
PLA	Male	3	131	2	64	45	13	130	51	439	62	21	522	512	2
	Female	0	19	0	14	10	1	28	7	79	14	4	97	91	6.6
	Total	3	150	2	78	55	14	158	58	518	76	25	619	603	2.7
URO	Male	7	146	1	94	34	12	124	39	457	68	30	555	547	1.5
	Female	0	12	0	8	3	0	17	8	48	9	4	61	55	10.9
	Total	7	158	1	102	37	12	141	47	505	77	34	616	602	2.3
VAS	Male	4	70	1	38	20	4	59	19	215	20	4	239	232	3
	Female	1	8	0	6	2	1	6	1	25	1	0	26	24	8.3
	Total	5	78	1	44	22	5	65	20	240	21	4	265	256	3.5
Sub Total	Male	88	1794	28	1059	476	106	1399	499	5449	884	405	6738	6643	1.4
	Female	11	207	2	123	63	11	205	55	677	111	46	834	786	6.1
	Total	99	2001	30	1182	539	117	1604	554	6126	995	451	7572	7429	1.9
OB & GYN	Male	0	6	0	1	0	0	14	0	21	0	1	22	22	0
	Female	0	0	0	0	0	0	0	0	0	0	0	0	0	-
	Total	0	6	0	1	0	0	14	0	21	0	1	22	22	0
OPH	Male	3	82	0	46	12	5	62	18	228	12	7	247	253	-2.4
	Female	0	14	1	2	0	0	11	1	31	2	0	33	35	-5.7
	Total	3	96	1	48	14	5	73	19	259	14	7	280	288	-2.8
Total	Male	91	1882	28	1106	488	111	1475	517	5698	896	413	7007	6918	1.3
	Female	11	221	3	125	65	11	216	56	708	113	46	867	821	5.6
	Total	102	2103	31	1231	553	122	1691	573	6406	1009	459	7874	7739	1.7

TABLE WFD 2 – Active RACS Fellows by location and speciality

Location & Speciality	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18	
CAR	Male	5	54	0	37	11	4	52	14	177	26	223	226	-1.3	
	Female	0	5	0	2	0	0	5	1	13	2	15	17	-11.8	
	Total	5	59	0	39	11	4	57	15	190	28	238	243	-2.1	
GEN	Male	18	496	16	269	124	22	396	121	1462	208	1795	1783	0.7	
	Female	5	98	2	56	26	5	91	27	310	42	375	353	6.2	
	Total	23	594	18	325	150	27	487	148	1772	250	2170	2136	1.6	
NEU	Male	7	71	0	44	11	6	57	18	214	20	24	258	-1.5	
	Female	1	11	0	8	6	1	8	1	36	1	38	34	11.8	
	Total	8	82	0	52	17	7	65	19	250	21	25	296	0	
ORT	Male	21	429	3	296	113	24	298	127	1311	265	1626	1594	2	
	Female	3	17	0	12	6	0	17	3	58	15	2	75	4.2	
	Total	24	446	3	308	119	24	315	130	1369	280	52	1701	1666	2.1
OTO	Male	8	129	3	84	41	7	95	36	403	76	22	501	0	
	Female	0	24	0	12	5	2	24	4	71	19	4	94	5.6	
	Total	8	153	3	96	46	9	119	40	474	95	26	595	5.6	
PAE	Male	2	25	0	11	4	2	17	5	66	14	17	97	0	
	Female	1	11	0	3	4	0	6	3	28	4	5	37	2.8	
	Total	3	36	0	14	8	2	23	8	94	18	22	134	0.8	
PLA	Male	2	111	2	54	38	11	121	40	379	51	19	449	0.4	
	Female	0	18	0	13	9	1	28	7	76	14	4	94	6.8	
	Total	2	129	2	67	47	12	149	47	455	65	23	543	1.5	
URO	Male	6	126	1	81	29	12	108	32	395	54	24	473	1.3	
	Female	0	12	0	8	3	0	17	8	48	9	4	61	10.9	
	Total	6	138	1	89	32	12	125	40	443	63	28	534	2.3	
VAS	Male	4	65	1	32	17	3	49	15	186	18	3	207	2.5	
	Female	1	8	0	6	2	1	6	1	25	1	0	26	8.3	
	Total	5	73	1	38	19	4	55	16	211	19	3	233	3.1	
Sub Total	Male	73	1506	26	908	388	91	1193	408	4593	732	304	5629	0.9	
	Female	11	204	2	120	61	10	202	55	665	107	43	815	768	6.1
	Total	84	1710	28	1028	449	101	1395	463	5258	839	347	6444	6347	1.5
OB & GYN	Male	0	1	0	0	0	0	0	0	1	0	1	1	-50	
	Female	0	0	0	0	0	0	0	0	0	0	0	0	-	
	Total	0	1	0	0	0	0	0	0	0	0	0	0	-50	
OPH	Male	2	66	0	30	9	3	52	11	173	5	4	182	-9.5	
	Female	0	13	1	2	0	11	1	29	2	0	31	33	-8.8	
	Total	2	79	1	31	11	3	63	12	202	7	4	213	-9.4	
Total	Male	75	1573	26	938	397	94	1245	419	4767	737	308	5812	5769	2.6
	Female	11	217	3	121	63	10	213	56	694	109	43	846	801	12.6
	Total	86	1790	29	1059	460	104	1458	475	5461	846	351	6658	6570	3.7

TABLE WFD 3 – Active RACS Fellows by location and age

Active Fellows by Location & Age	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018	TOTAL 2017	% Change 17/18	
<35	Male	1	16	0	10	3	2	23	1	56	16	10	82	188	-56.4
	Female	1	10	0	3	1	0	11	3	29	2	6	37	72	-48.6
	Total	2	26	0	13	4	2	34	4	85	18	16	119	260	-54.2
35-39	Male	8	141	2	85	34	6	125	38	439	74	32	545	472	15.5
	Female	1	44	1	28	11	1	49	10	145	25	8	178	156	14.1
	Total	9	185	3	113	45	7	174	48	584	99	40	723	628	15.1
40-44	Male	7	230	3	150	59	11	202	70	732	94	37	863	882	-2.2
	Female	3	54	1	45	16	1	49	16	185	28	10	223	193	15.5
	Total	10	284	4	195	75	12	251	86	917	122	47	1086	1075	1
45-49	Male	16	237	5	162	76	16	192	82	786	105	33	924	922	0.2
	Female	3	40	0	17	14	5	30	11	120	21	6	147	143	2.8
	Total	19	277	5	179	90	21	222	93	906	126	39	1071	1065	0.6
50-54	Male	12	218	5	150	42	8	143	64	642	110	29	781	748	4.4
	Female	2	25	0	14	8	1	27	9	86	12	4	102	90	13.3
	Total	14	243	5	164	50	9	170	73	728	122	33	883	838	5.4
55-59	Male	11	175	4	132	49	15	134	51	571	117	42	730	664	9.9
	Female	1	15	0	8	6	0	17	4	51	12	6	69	72	-4.2
	Total	12	190	4	140	55	15	151	55	622	129	48	799	736	8.6
60-64	Male	11	128	3	82	37	13	108	55	437	107	34	578	571	1.2
	Female	0	12	0	4	4	2	15	2	39	5	2	46	30	53.3
	Total	11	140	3	86	41	15	123	57	476	112	36	624	601	3.8
65-69	Male	3	118	2	53	33	10	88	19	326	56	39	421	428	-1.6
	Female	0	1	0	0	1	0	1	0	3	2	0	5	5	0
	Total	3	119	2	53	34	10	89	19	329	58	39	426	433	-1.6
70+	Male	4	243	2	84	55	10	178	28	604	53	48	705	704	0.1
	Female	0	3	0	1	0	0	3	0	7	0	1	8	7	14.3
	Total	4	246	2	85	55	10	181	28	611	53	49	713	711	0.3
Total	Male	73	1506	26	908	388	91	1193	408	4593	732	304	5629	5579	0.9
	Female	11	204	2	120	61	10	202	55	665	107	43	815	768	6.1
	Total	84	1710	28	1028	449	101	1395	463	5258	839	347	6444	6347	1.5
% of active Fellows under 55 years															
%	Male	60.3	55.9	57.7	61.3	55.2	47.3	57.4	62.5	57.8	54.5	46.4	56.8	57.6	-1.4
Female	90.9	84.8	100	89.2	82	80	82.2	89.1	85	82.2	79.1	84.3	85.2		
Total	64.3	59.4	60.7	64.6	58.8	50.5	61	65.7	61.2	58	50.4	60.2	60.9	-1.1	

Note: Data excludes OB&GYN and OPH.

TABLE WFD 4 – Active Australian RACS Fellows by speciality and age

Active Fellows by Speciality & Age	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	IVAS	TOTAL 2018	TOTAL 2017	% Change 17/18
<35												
Male	1	27	0	16	2	0	1	6	3	56	144	-61.1
Female	0	16	0	0	4	2	3	3	1	29	61	-52.5
Total	1	43	0	16	6	2	4	9	4	85	205	-58.5
35-39												
Male	10	144	17	132	35	3	34	37	27	439	386	13.7
Female	3	72	6	12	18	3	12	13	6	145	128	13.3
Total	13	216	23	144	53	6	46	50	33	584	514	13.6
40-44												
Male	17	228	30	227	64	7	61	70	28	732	759	-3.6
Female	2	87	7	19	21	4	24	14	7	185	162	21.7
Total	19	315	37	246	85	11	85	84	35	917	911	0.7
45-49												
Male	30	228	53	227	68	10	73	71	26	786	773	1.7
Female	3	59	10	7	12	4	12	9	4	120	120	0
Total	33	287	63	234	80	14	85	80	30	906	893	1.5
50-54												
Male	35	187	34	161	63	12	56	63	31	642	609	5.4
Female	1	37	9	7	9	3	9	8	3	86	75	14.7
Total	36	224	43	168	72	15	65	71	34	728	684	6.4
55-59												
Male	29	161	26	190	36	10	51	51	17	571	513	11.3
Female	0	20	2	8	5	9	6	1	0	51	53	-3.8
Total	29	181	28	198	41	19	57	52	17	622	566	9.9
60-64												
Male	24	132	18	125	39	8	37	38	16	437	437	0
Female	3	16	1	5	2	2	6	0	4	39	26	50
Total	27	148	19	130	41	10	43	38	20	476	463	2.8
65-69												
Male	0	1	0	0	0	0	2	0	0	326	336	-3
Female	16	122	13	92	26	8	17	20	12	3	3	0
Total	16	123	13	92	26	8	19	20	12	329	339	-2.9
70+												
Male	15	233	23	141	70	8	49	39	26	604	598	1
Female	1	2	1	0	0	1	2	0	0	7	6	16.7
Total	16	235	24	141	70	9	51	39	26	611	604	1.2
Total												
Male	161	1341	201	1219	377	58	364	375	174	4270	4555	-6.3
Female	29	431	49	150	97	36	91	68	37	988	624	58.3
Total	190	1772	250	1369	474	94	455	443	211	5258	5179	1.5
% Of Active Fellows under 55 years												
%	57.8	60.7	66.7	62.6	61.5	55.2	61.8	65.9	66.1	62.2	58.6	6
Female	31	62.9	65.3	30	66	44.4	65.9	69.1	56.8	57.2	85.9	-33.4
Total	53.7	61.2	66.4	59	62.4	51.1	62.6	66.4	64.5	61.2	61.9	-1.1

Note: Data excludes OB&GYN and OPH.

TABLE WFD 5 – Active New Zealand RACS Fellows by speciality and age

Active Fellows by Speciality & Age	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	IVAS	TOTAL 2018	TOTAL 2017	% Change 17/18
<35												
Male	0	9	0	5	1	0	0	0	1	16	32	-50
Female	0	1	0	0	1	0	0	0	0	2	5	-60
Total	0	10	0	5	2	0	0	0	1	18	37	-51.4
35-39												
Male	3	22	0	32	6	1	2	8	0	74	59	25.4
Female	1	10	0	3	4	1	2	3	1	25	22	13.6
Total	4	32	0	35	10	2	4	11	1	99	81	22.2
40-44												
Male	2	20	3	45	4	2	7	8	3	94	83	13.3
Female	0	10	0	2	6	0	7	3	0	28	28	0
Total	2	30	3	47	10	2	14	11	3	122	111	9.9
45-49												
Male	3	35	4	36	7	1	10	8	1	105	115	-8.7
Female	0	10	0	5	3	0	2	1	0	21	17	23.5
Total	3	45	4	41	10	1	12	9	1	126	132	-4.5
50-54												
Male	4	27	4	40	12	1	10	9	3	110	110	0
Female	0	6	0	1	2	0	2	1	0	12	13	-7.7
Total	4	33	4	41	14	1	12	10	3	122	123	-0.8
55-59												
Male	3	30	3	37	15	6	10	8	5	117	108	8.3
Female	1	4	1	2	1	2	0	1	0	12	12	0
Total	4	34	4	39	16	8	10	9	5	129	120	7.5
60-64												
Male	8	30	1	35	18	1	6	5	3	107	95	12.6
Female	0	1	0	2	1	0	1	0	0	5	3	66.7
Total	8	31	1	37	19	1	7	5	3	112	98	14.3
65-69												
Male	3	20	3	16	5	1	2	5	1	56	57	-1.8
Female	0	0	0	0	1	1	0	0	0	2	2	0
Total	3	20	3	16	6	2	2	5	1	58	59	-1.7
70+												
Male	0	15	2	19	8	1	4	3	1	53	59	-10.2
Female	0	0	0	0	0	0	0	0	0	0	0	-
Total	0	15	2	19	8	1	4	3	1	53	59	-10.2
Total												
Male	26	208	20	265	76	14	51	54	18	732	718	1.9
Female	2	42	1	15	19	4	14	9	1	107	102	4.9
Total	28	250	21	280	95	18	65	63	19	839	820	2.3
% Of Active Fellows under 55 years												
%	46.2	54.3	55	59.6	39.5	35.7	56.9	61.1	44.4	54.5	55.6	-1.9
Female	50	88.1	0	73.3	84.2	25	92.9	88.9	100	82.2	83.3	-1.3
Total	46.4	60	52.4	60.4	48.4	33.3	64.6	65.1	47.4	58	59	-1.7

TABLE WFD 6 – Active Australian RACS Fellows by speciality and age

Australian Active Fellows by RRMA & Speciality	M1	M2	R1	R2	R3	Rem1	Rem2	TOTAL 2018	% in M1/ M2 2018	TOTAL 2017	% in M1/ M2 2017	% Change in Metro 17/18
CAR	170	18	0	2	0	0	0	190	98.9	190	98.9	0
GEN	1243	166	174	142	39	7	1	1772	79.5	1739	79.9	-0.5
NEU	221	25	0	2	2	0	0	250	98.4	249	98.8	-0.4
ORT	1011	132	128	87	10	1	0	1369	83.5	1348	83.7	-0.2
OTO	364	43	41	19	6	1	0	474	85.9	470	86.6	-0.8
PAE	80	12	2	0	0	0	0	94	97.9	93	97.8	0.1
PLA	397	30	16	8	4	0	0	455	93.8	447	94	-0.2
URO	330	43	52	15	3	0	0	443	84.2	438	84	0.2
VAS	167	25	14	5	0	0	0	211	91	205	90.7	0.3
Total	3983	494	427	280	64	9	1	5258	85.1	5179	85.4	-0.3

Note: Data excludes OB&GYN and OPH.

TABLE WFD 7 – Active Australian RACS Fellows by RRMA and location

Australian Active Fellows by RRMA & Location	M1	M2	R1	R2	R3	Rem1	Rem2	TOTAL 2018	% in M1/ M2 2018	TOTAL 2017	% in M1/ M2 2017	% Change In Metro 17/18
ACT	83	0	1	0	0	0	0	84	98.8	85	98.8	0
NSW	1228	201	132	110	36	2	1	1710	83.6	1682	83.5	0.1
NT	3	22	0	0	0	3	0	28	89.3	28	100	-10.7
QLD	579	196	185	65	2	1	0	1028	75.4	1005	75.9	-0.7
SA	432	1	3	9	4	0	0	449	96.4	438	96.6	-0.2
TAS	63	0	29	6	3	0	0	101	62.4	95	61.1	2.1
VIC	1168	74	76	59	16	2	0	1395	89	1396	89.2	-0.2
WA	427	-	1	31	3	1	0	463	92.2	460	92.8	-0.6
Total	3983	494	427	280	64	9	1	5258	85.1	5179	85.4	-0.3

Note: Data excludes OB&GYN and OPH.

TABLE WFD 8 – Active Australian RACS Fellows by RRMA and age group

Australian Active Fellows by RRMA & Age	M1	M2	R1	R2	R3	Rem1	Rem2	TOTAL 2018	% in M1/ M2 2018	TOTAL 2017	% in M1/ M2 2017	% Change In Metro 17/18
≤35	64	10	3	5	3	0	0	85	87.1	205	91.2	-4.5
35-39	462	60	34	25	2	1	0	584	89.4	514	88.9	0.5
40-44	712	86	75	39	5	0	0	917	87	911	87.9	0.4
45-49	705	96	62	37	5	1	0	906	85.4	893	88.1	0.4
50-54	536	70	64	42	14	2	0	728	83.2	684	82.6	0.8
55-59	439	58	80	38	7	0	0	622	79.9	566	79.9	0
60-64	362	41	38	29	4	2	0	476	84.7	463	83.8	1
65-69	228	29	33	29	6	3	1	329	78.1	339	77.9	0.3
70+	475	44	38	36	18	0	0	611	84.9	604	86.4	-1.7
Total	3983	494	427	280	64	9	1	5258	85.1	5179	85.4	-0.3

Note: Data excludes OB&GYN and OPH.

TABLE WFD 9 – Active RACS SET Trainees obtaining RACS Fellowship in 2018 by location of residence and speciality

Location & Speciality	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018
CAR	0	0	0	1	0	0	1	0	2	0	2	4
Female	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	1	0	0	1	0	2	0	2	4
GEN	1	9	0	8	3	1	9	3	34	5	0	39
Female	0	8	0	5	1	0	5	0	19	2	1	22
Total	1	17	0	13	4	1	14	3	53	7	1	61
NEU	0	1	0	0	0	0	0	0	1	0	0	1
Female	0	3	0	0	1	0	0	0	4	0	0	4
Total	0	4	0	0	1	0	0	0	5	0	0	5
ORT	1	14	1	9	1	0	11	3	40	14	1	55
Female	0	1	0	1	1	0	0	0	3	0	0	3
Total	1	15	1	10	2	0	11	3	43	14	1	58
OTO	1	1	0	3	0	0	1	0	6	3	1	10
Female	0	0	0	1	0	0	2	1	4	1	0	5
Total	1	1	0	4	0	0	3	1	10	4	1	15
PAE	0	0	0	0	0	0	0	0	0	0	0	0
Female	0	1	0	0	0	0	0	0	1	0	0	1
Total	0	1	0	0	0	0	0	0	1	0	0	1
PLA	0	3	0	1	1	0	2	3	10	0	4	14
Female	0	2	0	0	2	0	2	0	6	0	1	7
Total	0	5	0	1	3	0	4	3	16	0	5	21
URO	0	4	0	1	1	0	2	0	8	1	2	11
Female	0	1	0	1	0	0	0	1	3	1	2	6
Total	0	5	0	2	1	0	2	1	11	2	4	17
VAS	0	2	0	2	1	0	1	0	6	1	0	7
Female	1	1	0	0	0	0	0	0	2	0	0	2
Total	1	3	0	2	1	0	1	0	8	1	0	9
Total	3	34	1	25	7	1	27	9	107	24	10	141
Female	1	17	0	8	5	0	9	2	42	4	4	50
Total	4	51	1	33	12	1	36	11	149	28	14	191

TABLE WFD 10 – Active International Medical Graduates obtaining RACS Fellowship in 2018 by location of residence and speciality

Location & Speciality	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUS	NZ	O/S	TOTAL 2018
CAR	0	0	0	0	0	0	0	0	0	0	0	0
Female	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0
GEN	0	1	1	1	1	0	6	0	10	1	0	11
Female	0	0	0	0	0	0	1	1	2	0	0	2
Total	0	1	1	1	1	0	7	1	12	1	0	13
NEU	0	0	0	0	0	0	0	0	0	0	0	0
Female	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0
ORT	0	2	0	0	1	1	2	1	7	0	0	7
Female	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	2	0	0	1	1	2	1	7	0	0	7
OTO	0	1	1	0	0	0	1	0	3	1	1	5
Female	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	1	1	0	0	0	1	0	3	1	1	5
PAE	0	0	0	0	0	0	1	0	1	0	0	1
Female	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	1	0	1	0	0	1
PLA	0	1	0	0	0	1	0	0	2	1	0	3
Female	0	0	0	0	0	0	0	1	1	0	0	1
Total	0	1	0	0	0	1	0	1	3	1	0	4
URO	0	0	0	0	0	0	1	0	1	0	0	1
Female	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	1	0	1	0	0	1
VAS	0	0	0	0	0	0	0	1	1	0	0	1
Female	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	1	1	0	0	1
Total	0	5	2	1	2	2	11	2	25	3	1	29
Female	0	0	0	0	0	0	1	2	3	0	0	3
Total	0	5	2	1	2	2	12	4	28	3	1	32

TABLE WFD 11 – Total number of SET Trainees and International Medical Graduates obtaining RACS Fellowship by speciality (2008 – 2018)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
CAR	10	6	5	11	5	15	4	7	10	4	4
Female	0	0	0	1	1	0	0	2	2	0	0
Total	10	6	5	12	6	15	4	9	12	4	4
GEN	62	47	63	54	64	57	55	65	74	68	50
Female	14	23	13	12	30	17	20	25	33	26	24
Total	76	70	76	66	94	74	75	90	107	94	74
NEU	14	7	12	6	9	5	6	18	9	11	1
Female	4	2	0	0	0	3	6	0	1	1	4
Total	18	9	12	6	9	8	12	18	10	12	5
ORT	41	67	49	60	59	61	38	60	66	54	62
Female	2	3	2	8	2	4	3	4	3	7	3
Total	43	70	51	68	61	65	41	64	69	61	65
OTO	9	12	16	21	12	15	14	14	13	12	15
Female	4	5	6	5	7	6	11	4	2	7	5
Total	13	17	22	26	19	21	25	18	15	19	20
PAE	3	2	3	2	4	2	4	5	1	4	1
Female	0	1	1	3	2	1	4	1	3	1	1
Total	3	3	4	5	6	3	8	6	4	5	2
PLA	19	7	7	18	22	14	13	11	15	11	17
Female	4	3	8	4	1	5	5	8	7	7	8
Total	23	10	15	22	23	19	18	19	22	18	25
URO	15	12	15	22	19	22	21	14	17	17	12
Female	3	3	3	3	3	5	6	1	6	3	6
Total	18	15	18	25	22	27	27	15	23	20	18
VAS	4	11	5	10	5	4	11	9	5	8	8
Female	1	1	0	2	2	2	4	1	2	0	2
Total	5	12	5	12	7	6	15	10	7	8	10
Total	177	171	175	204	199	195	166	203	210	189	170
Female	32	41	33	38	48	43	59	46	59	52	53
Total	209	212	208	242	247	238	225	249	269	241	223

FIGURE WFD 1 – Total annual number of SET Trainees and International Medical Graduates obtaining RACS Fellowship (2008–2017).

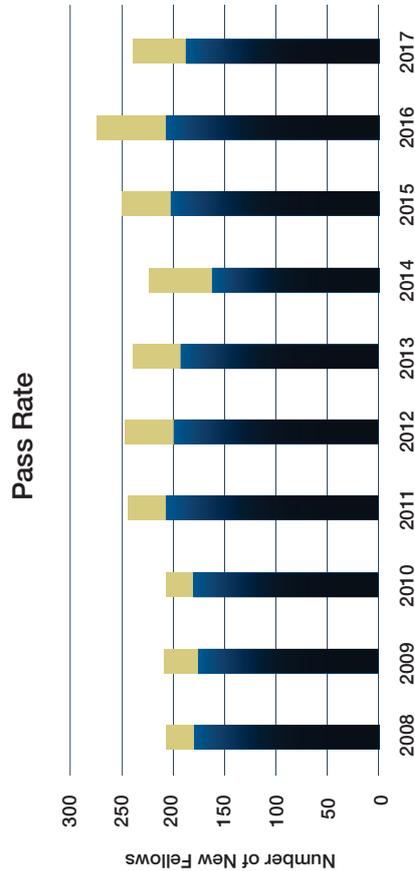


TABLE WFD 12 – Ratio of active Australian and New Zealand RACS Fellows per population by location

Location & Specialty	No Surgeons	Ratio of surgeons per 10,000 population	Population
ACT	84	2	420,902
NSW	1710	2.1	7,987,264
NT	28	1.1	247,281
QLD	1028	2	5,122,176
SA	449	2.6	1,736,389
TAS	101	1.9	528,097
VIC	1395	2.2	6,459,765
WA	463	1.8	2,956,877
AUS	5258	2.1	25,097,751
NZ	839	1.7	4,885,350

Data excludes Obstetrics & Gynaecology and Ophthalmology, Fellows.
 Population Source: Australian Bureau of Statistics website www.abs.gov.au and Statistics New Zealand website www.stats.govt.nz and is accurate as at June 2018.

TABLE WFD 13 – Ratio of active Australian and New Zealand RACS Fellows per population by location

Location & Specialty	No Surgeons	Ratio of surgeons per 1,000 population >=65 years	Population Over the Age of 65
ACT	81	1.5	53,648
NSW	1674	1.3	1,285,257
NT	28	1.5	18,765
QLD	1014	1.3	770,215
SA	441	1.4	319,596
TAS	99	1	104,028
VIC	1372	1.4	988,478
WA	455	1.2	374,251
AUS	5164	1.3	3,914,238
NZ	821	1.1	746,900

Data excludes the surgical specialties of Paediatric surgery, Obstetrics & Gynaecology and Ophthalmology.
 Population Source: Australian Bureau of Statistics website www.abs.gov.au and Statistics New Zealand website www.stats.govt.nz and is accurate as at June 2018.

SECTION SIX

PROFESSIONAL DEVELOPMENT AND STANDARDS

EXPLANATORY NOTES

All active Fellows have a requirement to participate in either the College Continuing Professional Development (CPD) program or in another CPD program approved by the College as meeting its standards for CPD. CPD program data is submitted to RACS in the year following participation, therefore the latest available 2017 CPD participation data are reported in Tables CPD.1 to CPD.5. Ophthalmologists who hold RACS Fellowship and participate in the RACS program have been included.

DATA HIGHLIGHTS

In 2017 there were 6,337 Fellows participating in the College CPD or other CPD approved program.

In 2017, 97% of Fellows complied with the RACS CPD Program. A key change to the CPD Program in 2017 was that all active Fellows must complete the RACS "Operating with Respect" eLearning module before the end of 2017, including Fellows residing overseas. The lower compliance rate when compared to 2016 is largely reflective of overseas Fellows not completing the module. Failure to comply constitutes a breach of the College's Code of Conduct and is managed via the RACS Professional Conduct Committee Regulations.

To facilitate the maintenance of surgical competence of Fellows, RACS provides professional development activities that are tailored to the specific needs of Fellows. These activities address the skills and knowledge required in each of the RACS nine surgical competencies.

During 2018, the Professional Development Department delivered education activities (face-to-face and eLearning) to a total of 1895 participants (1469 Fellows, 72 Trainees, 11 IMGs and 81 medical practitioners and health professionals). This included 68 Foundation Skills for Surgical Educator (FSSE) courses which were delivered as part of the RACS' Building Respect, Improving Patient Safety Action Plan.

While the number of courses delivered in 2018 was comparable to 2017, there was an overall decrease in the number of attendees. This decrease is largely due to a focus on delivering the Foundation Skills for Surgical Education (FSSE), which has a capped number of places available per course. In addition, RACS prioritised access and delivery of these courses in regional and rural Australia which influenced attendee numbers.

TABLE CPD 4 – Fellow participation in RACS and other CPD programs in 2017

CPD category	CAR	GEN	NEU	OPH	ORT	OTO	PAE	PLA	URO	VAS	Total	% Total
Operative practice in hospitals or day surgery units	198	1852	262	3	514	518	122	488	489	207	4653	91.2
Operative procedures in rooms only	0	10	0	1	0	3	0	2	2	0	18	0.4
Operative Practice as a locum only	2	20	1	0	5	6	1	0	3	0	38	0.7
Clinical consulting practice only	5	43	22	0	15	31	0	10	4	3	133	2.6
Other practice type	28	149	6	0	8	12	8	18	17	12	258	5.1
Total	233	2074	291	4	542	570	131	518	515	222	5100	100

TABLE CPD 5 – Registrations in RACS MOPS program in 2017

	AUS	NZ	O/S	Total registrations
Persons	11	18	1	30
IMGs	7	79	1	87
Total	18	97	2	117

Note: The category 'Persons' are surgeons who do not have a FRACS and are not on a pathway to Fellowship

TABLE CPD 6 – Professional Development participation by location and status

Location	Fellow	SET	IMG	non-IMGs/Trainee/Fellow	Total 2018	Total 2017	% change 17/18
ACT	23	3	0	3	29	35	-17.1
NSW	432	16	2	21	471	966	-50.7
NT	9	0	0	0	9	20	-55
QLD	224	10	1	12	247	528	-53.2
SA	125	7	1	6	139	226	-38.5
TAS	20	2	0	1	23	73	-68.5
VIC	336	14	2	24	376	991	-62.1
WA	76	2	0	2	80	232	-65.5
AUS Total	1245	54	6	69	1374	3081	-55.1
NZ	216	18	5	10	249	639	-61
O/S	8	0	0	2	10	25	-60
*Total	1469	72	11	81	1633	3725	-56.2

*face-to-face activities only; not including e-learning

TABLE CPD 7 – Professional Development participation by specialty and status

Specialty	2018	Total 2017	% Change 17/18
CAR	78	99	-21.2
GEN	539	1278	-57.8
NEU	96	155	-38.1
ORT	184	562	-66.7
OTO	149	359	-58.5
PAE	56	114	-50.9
PLA	161	283	-43.1
URO	138	384	-62.1
VAS	63	154	-59.1
Sub Total	1464	3358	-56.4
OPH	5	7	-28.6
SET	72	85	-15.3
IMG	11	40	-72.5
non-RACS	81	235	-65.5
*Total	1633	3725	-56.2

*face-to-face activities only; not including e-learning

TABLE CPD 1 – Participation in RACS CPD program 2015 - 2017 by specialty

Specialty	2015			2016			2017		
	Total required to participate	Total compliant	% compliant	Total required to participate	Total compliant	% compliant	Total required to participate	Total compliant	% compliant
CAR	229	229	100	236	234	99.2	231	223	96.5
GEN	1943	1942	99.9	2019	2014	99.8	2050	1970	96.1
NEU	281	281	100	286	285	99.7	290	279	96.2
ORT	525	525	100	544	544	100	541	523	96.7
OTO	561	561	100	571	568	99.5	570	563	98.8
PAE	129	129	100	128	128	100	132	127	96.2
PLA	503	503	100	515	511	99.2	515	505	98.1
URO	483	483	100	498	497	99.8	503	491	97.6
VAS	214	214	100	222	219	98.6	222	222	100
Sub Total	4868	4867	99.9	5019	5000	99.9	5054	4903	97
OB & GYN and OPH	7	7	100	6	6	100	5	4	80
Total	4875	4874	99.9	5025	5006	99.6	5059	4907	97.0

TABLE CPD 2 – Participation in RACS CPD program 2015 - 2017 by region

Location	2015			2016			2017		
	Total required to participate	Total compliant	% compliant	Total required to participate	Total compliant	% compliant	Total required to participate	Total compliant	% compliant
ACT	62	62	100	67	67	100	63	63	100
NSW	1283	1283	100	1323	1316	99.5	1346	1342	99.7
NT	25	25	100	24	24	100	25	25	100
SA	343	343	100	350	349	99.7	368	368	100
QLD	768	768	100	801	799	99.8	829	829	100
TAS	77	77	100	76	76	100	84	84	100
VIC	1085	1084	99.9	1122	1115	99.4	1129	1127	99.8
WA	377	377	100	394	383	97.2	378	378	100
AUS Total	4020	4019	99.9	4147	4129	99.6	4222	4216	99.9
NZ	535	535	100	555	554	99.8	563	563	100
O/S	320	320	100	323	323	100	315	163	51.7
Total	4875	4874	99.9	5025	5006	99.6	5100	4942	97

All active Fellows have a requirement to participate in either the College CPD program or in another CPD program approved by the College as meeting its standards for CPD. In 2017 there were 6337 Fellows participating in the College CPD or other CPD approved program. Ophthalmologists who held RACS Fellowship have been included.

TABLE CPD 3 – Fellow participation in RACS and other CPD programs in 2017

College CPD Programs	Number of participating Fellows	% of participating Fellows
Royal Australasian College of Surgeons	5105	82.4
Australian Orthopaedic Association	867	13.6
New Zealand Orthopaedic Association	250	3.9
Royal Australian and New Zealand College of Ophthalmologists	203	0.1
Other	2	0
Total	6337	100

APPENDIX A: DEFINITIONS FOR REGIONAL AND RURAL DATA

RRMA CODES

The Rural, Remote and Metropolitan Area code (RRMA) is used to help classify healthcare facilities across Australia according to the types of communities they serve. The RRMA code divides Australia into areas according to city status, population, rurality and remoteness.

USE OF POSTCODE TO DETERMINE REGION

The allocation of Fellows to regions and RRMA classification is determined by the postcode from each Fellow's preferred mailing address as of December 2018. The last known mailing address was used if the current address was unknown.

Rural Remote and Metropolitan Areas Classification & Population Size

RRMA CODE	DEFINITION	POPULATION SIZE	EXAMPLES
M1	Capital cities	> 500,000	Sydney, Melbourne, Brisbane, Perth, Adelaide, Hobart, Darwin and Canberra
M2	Other metropolitan centres	100,000 – 499,999	Newcastle, Wollongong, Queanbeyan (part of Canberra-Queanbeyan), Geelong, Gold Coast-Tweed Heads, Townsville
R1	Large rural cities	25,000 – 99,999	Albury-Wodonga, Dubbo, Lismore, Orange, Port Macquarie, Tamworth, Wagga Wagga (NSW); Ballarat, Bendigo, Shepparton-Mooroopna (VIC); Bundaberg, Cairns, Mackay, Maroochydore-Mooloolaba, Rockhampton, Toowoomba (QLD); Whyalla (SA); and Launceston (TAS)
R2	Small rural centres	10,000 – 24,999	Armidale, Mildura, Hervey Bay, Mount Gambier, Bunbury, Devonport
R3	Other rural centres	< 10,000	Cowra Shire, Temora Shire, Guyra Shire (NSW); Ararat Shire, Cobram Shire (Vic); Cardwell Shire, Whitsunday Shire (Qld); Barossa, Pinnaroo (SA); Moora Shire, York Shire (WA); George Town, Ross (TAS); Coomalie, Litchfield (NT)
Rem 1	Remote centres	25,000 – 99,999	Broome, Kalbarrie/Boulder, Alice Springs
Rem 2	Other remote centres	10,000 – 24,999	Bourke, Orboost, Quilpie, Coober Pedy, Shark Bay, King Island, Gove

Source: Rural, Remote and Metropolitan Area (RRMA) classification developed by the Commonwealth Departments of Primary Industries and Energy and Health and Family Services (DPE & DHFS 1994).



Annual Activities Report January – December 2018
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Appendix 9 Policy: Selection to Surgical Education and Training

POLICY		ROYAL AUSTRALASIAN COLLEGE OF SURGEONS	
Division:	Education and Training Administration	Ref. No.	ETA-SET-005
Department:	Surgical Training		
Title:	Selection to Surgical Education and Training		

1. PURPOSE AND SCOPE

The Surgical Education and Training (SET) Program is open to doctors who are able to satisfy the College's eligibility requirements. This policy details the principles and standards that apply to the conduct of the annual selection process.

In determining these principles, the College has been informed by the accreditation requirements of the Australian Medical Council (AMC), the Medical Council of New Zealand (MCNZ), the Report into Trainee Selection in Australian Medical Colleges, January 1998 (The Brennan Report) and current surgical education literature.

2. KEYWORDS

Selection; Eligibility; Surgical; Education; Training; Criteria; SET; Standards

3. BODY OF POLICY**3.1. Selection**

- 3.1.1. Selection to the College's Surgical Education and training program is undertaken by the Specialty Training Boards in collaboration with the relevant specialty societies as determined by the applicable Collaboration, Service or Partnering Agreement.
- 3.1.2. Selection aims to identify those doctors with the values, attitudes and aptitude required to become competent surgeons.
- 3.1.3. The selection process may involve assessment of an applicant's knowledge, skills, and behaviour and may take into account their clinical experience, academic and other achievements.
- 3.1.4. The selection process for the individual SET programs – including prerequisites - must be clearly defined and publicly available to potential applicants.
- 3.1.5. Detailed specialty selection regulations, which have been assessed for compliance with this policy, are publicly available in November prior to the year of selection.
- 3.1.6. Applicants are assessed using multiple tools, each of which utilise multiple raters, who are provided with clear criteria for marking. Each selection tool has a published maximum score.
- 3.1.7. Tools used in selection typically include curriculum vitae, referee reports and interviews. Referee reports should include the performance of the applicant at work. Other tools suitable for trainee selection process may also be used.
- 3.1.8. Applicants may be short-listed for progression in the selection process based on one or more tools.
- 3.1.9. Applicants are ranked either nationally (where the selection process in New Zealand is separate from that in Australia) or bi-nationally (where the selection process is common to Australia and New Zealand). Posts are offered in accordance with the final ranking, subject to clause 3.2 below.
- 3.1.10. Notification of the outcome for each specialty selection process must be released on the common announcement dates, as approved by the Board

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Document Owner	Manager, Surgical Training	Version:	8
		Approval Date:	November 2018
		Review Date:	November 2019

POLICY		ROYAL AUSTRALASIAN COLLEGE OF SURGEONS	
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Selection; Eligibility; Surgical; Education; Training; Criteria; SET; Standards

3. BODY OF POLICY

3.1. Selection

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Appendix 10 Policy: Surgical Education and Training Fee

POLICY		ROYAL AUSTRALASIAN COLLEGE OF SURGEONS	
Division:	Education and Training Administration	Ref. No.	ETA-SET-028
Department:	Surgical Training		
Title:	Surgical Education and Training (SET) Fee		

1. PURPOSE AND SCOPE

This policy defines the Surgical Training Fees payable to RACS for generic education services to trainees on Surgical Education and Training (SET) program.

2. KEYWORDS

Surgical Education and Training, SET, Faculty of Specialty Training, Specialty Society, fees.

3. BODY OF POLICY**3.1. Background**

The pre-fellowship Education program of RACS is funded from training fees and associated fees for skills courses and examinations, and is not subsidised by Fellowship member subscriptions.

Trainees on the SET program will be charged a fee with two components:

3.1.1. RACS SET Fee; and

3.1.2. Specialty SET Fee

3.2. Surgical Education and Training (SET) Fee

3.2.1. The SET Fee is approved by October Council each year and is published on the RACS website.

3.2.2. Trainees in active clinical training for more than 6 months of the training year are invoiced at 100% of the published fee.

3.2.3. Trainees in active clinical training for 6 months or less of the training year are invoiced at 50% of the published fee.

3.2.4. Trainees in accredited surgical research for 6 months or more of the training year are invoiced at 50% of the published fee.

3.2.5. Trainees not in clinical training or accredited research (e.g. on interruption, deferral, exam pending or other) for the full training year are invoiced at 10% of the published full-time training fee.

3.2.6. Fellows of RACS who undertake training conducted by RACS in another specialty must pay the relevant training fee, but are exempted from Fellowship Subscriptions for the period of training.

3.3. Specialty Surgical Educational and Training Fee (SSET)

Refer to the Specialty Surgical Education and Training Fee policy.

3.4. Refunds

3.4.1. Only trainees in clinical rotations or undertaking accredited research who voluntarily withdraw from training before April 1 are entitled to a refund, the refund being 50% of the levied fee. No other trainees are entitled to refunds including those within the scope of 3.4.2 or 3.4.3.

3.4.2. No refund is available to trainees not in clinical training or on unaccredited research (i.e. trainees charged 10% of the full-time training fee).

3.4.3. No refund is available to trainees dismissed from the training program.

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POLICY

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Division:	Education and Training Administration	Ref. No.	ETA-SET-028
Department:	Surgical Training		
Title:	Surgical Education and Training (SET) Fee		

3.5. Instalment Payments

- 3.5.1. Trainees may elect to pay by instalments, on the dates specified on the invoice.
- 3.5.2. Election to pay by instalment must be made by the payment due date on the invoice, and is a commitment to pay all instalments on or by the instalment date.
- 3.5.3. An instalment processing fee of \$250.00 is payable.
- 3.5.4. RACS may refuse the instalment payment plan to trainees with a prior history of failing to pay instalments by the due date. Such trainees will be advised in writing that they are not eligible to pay by instalment prior to invoices being issued.

3.6. Non-payment of Fees

- 3.6.1. RACS will initiate credit management processes where fees (including any Specialty Surgical Education and Training Fee included in the RACS invoice) remain outstanding at the invoice due date and the trainee has not nominated to pay by instalment. Trainees will be notified in writing of a final due date, not less than 10 working days from the original due date.
- 3.6.2. The Specialty Board Chair will be advised of trainees with outstanding invoices.
- 3.6.3. Where fees remain outstanding after the final due date trainees will be automatically dismissed from training.
- 3.6.4. Trainees with an instalment payment outstanding for more than 14 calendar days after the instalment payment date will be automatically dismissed from training.
- 3.6.5. Trainees who are terminated from training for non-payment of fees may be entitled to reapply to surgical training in accordance with RACS Policy on Former Trainees Seeking to Re-apply to Surgical Training.

4. ASSOCIATED DOCUMENTS

Policy: Specialty Surgical Education and Training Fee

5. GLOSSARY

Exam Pending	A trainee who has completed the required clinical rotations of training but has yet to complete the non-clinical elements and/or the Fellowship Examination.
Interruption	A period of leave from the training program. This may also involve leave from the clinical rotation, which is arranged separately by the trainee with the employer.
Deferral	A delay to the commencement of the Surgical Education and Training program
Suspension	A temporary prohibition or exclusion from participation in the SET program
Accredited Research	Research undertaken by a trainee that is recognised by the Board as contributing to the completion of the SET program.

Approver: Education Board
Authoriser: Council

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Standards for Supervision



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The SET program and supervision

The Royal Australasian College of Surgeons (RACS), is responsible for the delivery of the RACS Surgical Education and Training (SET) program, through its Specialty Training Boards (STBs) and in collaboration with Specialty Society partners. The STBs are responsible for the selection, assessment, supervision and management of surgical trainees in accredited hospital-based training posts, under the direction of appointed supervisors.

The SET program relies on the significant *pro bono* commitment of Fellows who undertake the supervisor role. Supervisors, who are RACS Fellows in the relevant specialty, offer their time and expertise to train the independent surgical consultants of the future and to ensure that the Australian and New Zealand communities receive healthcare at continuing world class standards.

RACS recognises the multiple responsibilities of surgeons as they provide patient care and manage clinical risks, in addition to delivering comprehensive training and supervision. Sharing knowledge and expertise with the next generation of surgeons is one of the most significant contributions an individual Fellow can make to the community and to the collegiality of RACS.

Supervisor, as a nomenclature, means the designated supervisor for the specialty for an accredited training post at the hospital. Other terms are sometimes used by STBs and are defined in individual STB training regulations.

Standards for supervisors

To assist supervisors in their roles in educating and assessing trainees for the relevant STBs, RACS has developed a set of standards. The standards outline the attributes, roles and responsibilities and effective teaching methods for supervisors, who model the integration of the RACS competencies into daily practice. Defined standards of educational practice for supervisors are necessary to improve and maintain high-quality surgical education and training.

The standards for supervisors are consistent with the accreditation standards of the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) that govern specialist medical colleges.

The RACS Building Respect, Improving Patient Safety Action Plan⁽¹⁾ identifies the need for supervisors to be equipped with appropriate teaching, interpersonal and leadership skills in order to educate trainees. The standards provide a framework to clarify the expectations of the supervisory role and can be referenced as a guide to improve the quality of clinical teaching and learning⁽²⁾.

The standards encompass the nine RACS competencies that are incorporated into the SET program. The [Becoming a Competent and Proficient Surgeon: Training Standards for the Nine RACS Competencies](#)⁽³⁾ provides guidance for supervisors, trainers and trainees to stage training in each of the competencies.

Supervisors as teachers and assessors

Supervisors of training are key personnel in guiding and supporting trainees in their workplace learning and in the assessment of that learning. The workplace is the richest environment for trainees to gain the knowledge, skills and behaviours required for practising clinicians⁽⁴⁾. Real life activities engage the trainee on a higher cognitive level and are the foundation of the SET program. Situated learning encourages the learning and consolidation of new skills, knowledge and behaviours. Interacting with role models and responding to feedback assists trainees to attain professional behaviours.

Work-based learning and assessment, as outlined in the [RACS Work-based Assessment: A practical guide](#)⁽⁵⁾, facilitates the integration of multiple competencies. Relating the learning to different contexts encourages the trainee to review and reconnect their knowledge and skills. This strengthens long-term memory, information retention, retrieval and the transfer of learning.⁽⁶⁾

Supervisor responsibilities aligned to RACS competencies

The responsibilities at the core of clinical supervision and trainee support can be mapped to the RACS competencies.

Principal Responsibility	Collaboration and Teamwork	Communication	Health Advocacy	Judgement-Clinical decision Making	Management & Leadership	Medical Expertise	Professionalism & Ethics	Scholarship & Teaching	Technical Expertise
1. Demonstrates all RACS competencies with patients and all work healthcare workers	X	X	X	X	X	X	X	X	X
2. Undertakes trainee orientation	X	X			X		X	X	
3. Ensures trainees receive appropriate training, observation, assessment and feedback		X			X			X	
4. Leads in-training assessment	X	X		X	X	X	X	X	
5. Guides trainees' personal and professional development	X	X	X		X		X	X	
6. Liaises with the training board and/or regional subcommittee regarding their trainees' performance and wellbeing		X	X		X		X	X	
7. Provides feedback at scheduled performance reviews and when underperformance has been identified		X	X		X	X	X	X	
8. Coordinates, in liaison with the boards, the remediation process for a trainee with identified underperformance in rotations and/or assessment tasks, including the early and Fellowship examinations	X	X		X	X	X	X	X	

Supervisor role

Supervisors are crucial to meeting the community's need for safe and effective clinical care. Supervisors ensure safe medical practice while facilitating the learning of future surgeons.

The aim of supervision is to facilitate trainees to become competent surgeons who provide consistently safe and effective surgical care of the highest standard to the Australian and New Zealand communities.

Effective supervision enables trainees to develop their practice safely and in supportive environments that expedite the acquisition of knowledge, skills and professionalism. Supervision promotes a culture of continuous learning and professional development⁽⁷⁾.

The [RACS Surgical Supervisors^{\(8\)}](#) policy, in conjunction with the relevant specialty training program Training Regulations, details the full role and responsibilities of supervisors.

Supervisor attributes

The attributes of an effective supervisor include:

- Competent practitioner
- Reflective and emotionally intelligent
- Motivated to develop educational practice
- Consistently models high standards of professional behaviour
- Well organised
- Develops rapport with trainees
- Manages conflicts of interests
- Available and responsive
- Communicates and collaborates effectively
- Enthusiastic educator

Supervisor support

RACS and the STBs support supervisors by ensuring that supervisors develop the knowledge, skills and behaviours necessary for the role. This is achieved by ensuring that supervisors:

- are appropriately orientated and inducted to their role and responsibilities
- are informed of and are able to access relevant professional development activities; and
- have opportunities for feedback on their performance and opportunities to further develop their supervisory skills

Principal responsibilities of a surgical supervisor

Surgical supervisors, irrespective of speciality, will perform tasks aligned to eight principal responsibilities that are the core of clinical supervision and trainee support. The following table lists those responsibilities and related tasks that are reflective of an effective supervisor. Each responsibility can also be mapped to the RACS competencies.

Principal Responsibility	Related Tasks
1. Demonstrates all RACS competencies with patients and all healthcare workers	<ul style="list-style-type: none"> Role models professional behaviour at all times Ensures patient safety Leads positive cultural change Ensures compliance with training accreditation standards
2. Undertakes trainee orientation	<ul style="list-style-type: none"> Conducts or coordinates post/workplace induction (e.g. systems, protocols, OHS, HR) In conjunction with the trainee, develops learning goals and plans aligned to curriculum and trainee's level of performance Identifies and undertakes learning opportunities Empowers trainees to undertake self-directed learning
3. Ensures trainees receive appropriate training, observation, assessment and feedback	<ul style="list-style-type: none"> Ensures that training and assessments are aligned to curricula and trainees' knowledge and skills Liaises with trainers regarding trainee learning goals and plans Directs trainees to learning opportunities and resources Observes trainees and provides regular, specific feedback to guide trainee performance
4. Leads in-training assessment	<ul style="list-style-type: none"> Liaises with trainers to provide comprehensive mid-term formative assessments and end-of-term summative assessments. Modifies trainees' learning goals and plans where indicated. Complies with STB and RACS assessment and reporting requirements
5. Guides trainees' personal and professional development	<ul style="list-style-type: none"> Is available for and provides confidential advice on trainees' concerns including career advice, wellbeing Encourages open communication with trainees Encourages trainees to establish work-life balance, e.g. by providing advice regarding flexible training options, career trajectories and leave. Facilitates trainees to reflect on decision-making and performance Advocates (with Board and employers) for trainee education and career opportunities

Principal Responsibility	Related Tasks
6. Liaises with the training board and/or regional subcommittee regarding their trainees' performance and wellbeing	<ul style="list-style-type: none"> Informs board/regional committee regarding trainee performance Advocates for trainee wellbeing Alerts training board regarding trainee underperformance Identifies trainee stress, fatigue and underperformance, and acts to address these
7. Provides feedback at scheduled performance reviews and when underperformance has been identified	<ul style="list-style-type: none"> Adopts effective methods for providing timely, constructive and respectful feedback to guide learning and performance Identifies trainee underperformance and communicates this appropriately Regularly documents examples of trainee performance Highlights and reinforces satisfactory performance
8. Coordinates, in liaison with the boards, the remediation process for a trainee with identified underperformance in rotations and/or assessment tasks, including the early and Fellowship examinations	<ul style="list-style-type: none"> Helps trainee to identify areas for improvement Works with trainee to clarify agreed standards of performance Assists in developing specific strategies for supporting improvement in performance Regularly monitors trainee performance and wellbeing Complies with reporting requirements

RACS resources for supervisors

Publications

- RACS Becoming a Competent and Proficient Surgeon: Training standards for the Nine RACS Competencies, outlines the nine competencies and describes the stages of progress from a pre-vocational doctor to a competent clinician(3).
- RACS Surgical Competence and Performance: A guide to aid the assessment and development of surgeons. The framework provides a structured conceptual map of the learning outcomes of the SET program(s): description s of surgical performance as behaviours(9).
- RACS Work-based Assessment: A practical guide for building an assessment system around work(5).

Courses

- Foundation Skills for Surgical Educators – mandatory
- Operate with Respect - mandatory
- Surgical Teacher's Course - desirable
- Supervisors and Trainers for Surgical Education and Training (SATSET) (or module)
- Keeping Trainees on Track (KTOT) (or module)
- Clinical Decision Making
- Critical Literature Evaluation and Research (CLEAR)

Forums

- Academy of Surgical Educators Forum
- Academy Educator Studio Sessions - webinar

eLearning modules

- Let's Operate with Respect - mandatory
- Keeping Trainees on Track (KTOT)
- Supervisors and Trainers for Surgical Education and Training (SATSET)
- Trainees in Difficulty
- Standards of Performance
- Goal Setting
- Self-Assessment

RACS co-badged programs with the University of Melbourne

- Graduate Certificate in Surgical Education
- Graduate Diploma in Surgical Education
- Masters in Surgical Education

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Appendix 12 Policy: Assessing an IMG's comparability to an Australian and New Zealand trained surgical specialist

POLICY		ROYAL AUSTRALASIAN COLLEGE OF SURGEONS	
Portfolio:	Education	Ref. No.	ETA-IMG-038
Department:	International Medical Graduates		
Title:	Assessing an IMG's Comparability to an Australian and New Zealand Trained Surgical Specialist		

1. PURPOSE AND SCOPE

The standards of practice of the Royal Australasian College of Surgeons (RACS) Surgical Education and Training (SET) program (including AOA 21 Program for orthopaedics) have been accepted by the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) as those required for registration to practice as a surgical specialist.

An International Medical Graduate (IMG) is a doctor who has undertaken a specialist surgical training program outside Australia and New Zealand and is seeking to be assessed for comparability to an Australian and New Zealand trained surgeon.

When assessing an IMG for comparability, RACS will consider the training program completed and subsequent to that any further training, assessment, experience, recent practice and continuing professional development (CPD) undertaken by the IMG to determine whether all these components will enable the IMG to practice at a level comparable to the standard expected of an Australian and New Zealand trained surgical specialist commencing in the same field of practice.

In accordance with the requirements of the MBA, and with respect to the Specialist Assessment of International Medical Graduates in Australia policy {ETA-IMG-006}, the Board of Surgical Education and Training (BSET) or Executive BSET will determine if an IMG's training and experience, in comparison to an Australian and New Zealand trained surgical specialist is:

- a. Substantially Comparable
- b. Partially Comparable, or
- c. Not Comparable.

This policy defines the process for assessing the comparability of an IMG to an Australian and New Zealand trained surgical specialist.

2. KEYWORDS

International Medical Graduate (IMG), Comparability, Examination, Surgical, Specialist, Training, Education, Experience.

3. RECENCY OF PRACTICE

3.1. Assessing Recency of Practice

- 3.1.1. An IMG will be regarded as having recent clinical practice if they have documented evidence that demonstrates that in the last 2 years they have:
 - a. Evidence of medical and specialist registrations; and
 - b. A certificate of good standing or equivalent; and
 - c. A minimum of 12 months practice in the relevant surgical specialty; and
 - d. A minimum of 6 months of continuous practice in the relevant surgical specialty; and
 - e. A minimum of 100 major cases as primary operator; and
 - f. Evidence of involvement in the following areas of Continuing Professional Development:

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- Peer reviewed audit
- Maintenance of knowledge and skills

4. COMPARABLE SPECIALIST SURGICAL TRAINING

4.1. The Comparability Framework

- 4.1.1. In making the assessment of comparability, the assessors will identify the common features of the training program completed by the IMG to the components of the SET program (including AOA 21). Reference to a comparable training program indicates that it has common features to the SET program but does not imply that it is identical.
- 4.1.2. Implicitly or explicitly, the training program being assessed will need to demonstrate that it incorporates teaching and assessment of the competencies of:
- Collaboration
 - Communication
 - Health advocacy
 - Judgement - clinical decision making
 - Management and leadership
 - Medical expertise
 - Professionalism
 - Scholar and teacher
 - Technical expertise
- 4.1.3. In the assessment process RACS relies on documentation provided by the IMG to demonstrate comparability of their education and training. RACS is not obliged to assume comparability where evidence is not provided, or to actively seek additional information to supplement that which has been provided.

4.2. Common Features required of a Comparable Education and Training Program

- 4.2.1. A comparable education and training program will have been accredited by an external accreditation agency whose role is similar to the Australian Medical Council (AMC) and the MCNZ in assessing minimum standards in specialist medical education.
- 4.2.2. A comparable education and training program will include experience in accredited training positions that:
- Provided individual rotations not less than three months in duration.
 - Were located at more than one teaching institution, or, if at one institution, included rotations in 3 or more units.
 - Included operative experience both assisting and as primary operator under supervision, with an increase in responsibility over the life of the program.

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- d. Provided exposure to the teachings and practices of multiple surgeons.
- e. Formative and summative in-training assessment of technical and non-technical competencies which must have been undertaken by multiple surgeons. Such assessment examples include Direct Observation of Procedural Skills (DOPS) and mini Clinical Examination (Mini-CEX).
- f. Provided for the involvement in the full spectrum of care of patients pre and post operatively and in emergency, acute and elective settings and the opportunity for the trainee to develop independent decision making pre and postoperatively in the management of patients.
- g. Provided exposure to weekly consultant supervised outpatient clinics or other clinics where independent but supervised decision making in the preoperative and postoperative setting is possible.
- h. Provided experience covering a similar range of procedures, approaches and treatments to the SET program (including AOA 21).

4.2.3. Evidence of the training program completed must include:

- a. A copy of the training program curriculum that pertains to the period that the IMG completed the training program; and
- b. A copy of the training program regulations and/or policies that pertains to the period that the IMG completed the training program.

4.2.4. The training program will have included research through projects or courses that develop research skills.

4.2.5. Recognising that some skills are best developed by specific intensive courses, graduates of a comparable education and training program will have undertaken specific training courses such as surgical skills, the emergency management of severe trauma, care of the critically ill surgical patient and radiation safety.

4.2.6. Specific requirements for each specialty are listed in Appendix A.

4.3. Comparable Exit Examination

4.3.1. It is expected that an exit examination will assess the competencies of:

- a. Judgement - Clinical Decision Making
- b. Medical Expertise
- c. Communication

4.3.2. The exit examination should include:

- a. Examination of candidates by multiple external examiners using a predetermined scoring system; and
- b. Multiple examination segments that include written and oral examination of a candidate's ability to demonstrate attainment of the required competencies.

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- 4.3.3. Given the difficulties of comparing the standard of examinations from around the world, RACS does not recognize any particular examination as being comparable to the RACS Fellowship Examination (FEX). It will assess the examination process together with the training undertaken by the IMG.

4.4. Post Graduate Training and Experience

- 4.4.1. Many overseas training programs have some deficiencies or differences as compared to Australian and New Zealand surgical education and training program. These deficiencies include the duration of training, the number of cases performed during training, the number of institutions involved in training, the number of surgeons involved in training and the breadth of training. Many surgeons go on to further, less structured positions, which may be described as Fellowships, Senior Registrar positions or similar. If a position is to be considered as part of the overall training package of the IMG there should be evidence that the position has all of the following features:

- a. Addresses identified gaps in the training program
- b. Enables acquisition of new and/or reinforcement of existing skills
- c. Has exposure to multiple surgeons
- d. Has a significant volume of primary operating
- e. Allows independent clinical decision making
- f. Involves responsibility for patient management
- g. Include documented structured feedback or assessment which confirms a level of proficiency equivalent to Consultant level

Specific evidence is required. This must include logbooks summaries, position descriptions, and reports from supervisors which indicate the IMGs performance across all RACS nine competencies.

4.5. Depth and Scope of Practice

- 4.5.1. If an IMG has less than 5 years of consultant practice they will be judged at most, as partially comparable and if so, will be required to undertake the Fellowship Examination.
- 4.5.2. If an IMG has 5 or more years of independent consultant level practice the depth and scope of that practice will be assessed.
- 4.5.3. Independent practice must include responsibility for, and decision making regarding pre-operative, intra-operative and post-operative care.
- 4.5.4. The standard of comparison is that of an ANZ trained surgeon with 5 or more years of independent practice. To meet this requirement the IMG must demonstrate that they have the ability to:
- a. manage emergency presentations across the breadth of the specialty
 - b. perform a suitable range of emergency procedures
- 4.5.5. It is recognised that the scope of many surgeon's practice becomes narrower over time but must include the ability to manage the relevant

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specialty specific presentations as listed in Appendix B. There is no expectation that the IMG will perform the whole range of the specialty. A practical test would be to consider whether or not the IMG could safely be on call at a medium sized hospital.

4.6. Non-Technical Skills

- 4.6.1. Non-technical competencies are extremely important to all surgeons. RACS requires all referee reports to address all 9 RACS competencies (including AOA 21).
- 4.6.2. At interview a series of structured questions and scenarios will be utilized to assess the non-technical competencies of the IMG. The results of this assessment will be highly influential in the final determination of comparability.

5. ASSOCIATED DOCUMENTS

Policies

Specialist Assessment of International Medical Graduates in Australia

Guidelines

Guidelines for Applicants: Information for International Medical Graduate Applicants

Approver: Education Board

Authoriser: Council

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Appendix A: Specialty Specific Training Requirements

This document defines the standards applied by each surgical specialty in assessing the comparability of an IMG to an Australian and New Zealand trained surgeon within the same surgical specialty.

1. CARDIOTHORACIC SURGERY

- i) Competence in cardiac thoracic surgery with a minimum of 24 months supervised training in a Board approved institution. The training requirements are in line with SET 5 and SET 6 Cardiothoracic trainees.
- ii) Competence in paediatric surgery as assessed by the Board approved Paediatric unit.

2. GENERAL SURGERY

- i) Minimum of 48 months of training in general surgery and its subspecialties.
- ii) Minimum of 300 major cases as primary operator.
- iii) Competence in diagnosis and treatment in the following areas:
 - Abdominal wall
 - Bariatric
 - Breast
 - Colo-ano-rectal
 - Endocrine
 - Head and neck
 - Hepatobiliary and pancreatic
 - Lymphatic system and spleen
 - Oesophago-gastric
 - Skin and soft tissue
 - Small bowel
- iv) Competence in recognising and managing sepsis, trauma and other acute surgical conditions.
- v) Competence in gastroscopy and colonoscopy (diagnostic and therapeutic).

3. NEUROSURGERY

- i) Minimum of 60 months of training in neurosurgery, undertaken in more than one training institution over the life of the training program.
- ii) Involvement in 1200 major neurosurgical cases including both assisting and as the primary operator under supervision with an increase in responsibility over the life of the training program.
- iii) Experience in operative procedures covering the full range of neurosurgical procedures, approaches and treatments provided in the SET program.
- iv) Participation in neurosurgical research and research outcomes comparable to that required in the SET program.

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4. ORTHOPAEDIC SURGERY

- i) Minimum of 48 months of training in orthopaedic surgery.
- ii) Exposure and assessment as primary surgeon to the breadth of orthopaedic practice including:
 - Elbow
 - Foot and ankle
 - Hand and wrist
 - Hip
 - Knee
 - Paediatrics
 - Shoulder
 - Spine
 - Systemic medical conditions
 - Tumour and tumour-like conditions
 - Trauma and injury
- iii) Exposure to, and assessment in, the non-technical (AOA 21 Foundation) competencies.

5. OTOLARYNGOLOGY HEAD AND NECK SURGERY

- i) Minimum of 60 months of training in otolaryngology head and neck surgery.
- ii) Minimum of 250 type A cases (as per RACS MALT logbook)
- iii) Minimum of 250 type B cases (as per RACS MALT logbook)
- iv) Minimum of 50 type A cases in each of Head and Neck, Otology and Rhinology
- v) Exposure to and competence in the following areas:
 - Facial plastics
 - Head and neck
 - Laryngology
 - Otology
 - Paediatric otolaryngology
 - Rhinology

6. PAEDIATRIC SURGERY

- i) Minimum of 72 months of training.
- ii) Proficiency in basic sciences including anatomy and embryology applicable to the practice of paediatric surgery.
- iii) Competence in the following areas as expected by the end of RACS Senior SET, laid out in RACS Paediatric Surgery curriculum:
 - Abdominal
 - Abdominal wall
 - Genito-urinary
 - Head and neck
 - Inguinoscrotal
 - Neonatal
 - Paediatric oncology

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- Skin and appendages
- Thoracic (non cardiac)
- Trauma and burns

7. PLASTIC AND RECONSTRUCTIVE SURGERY

- Minimum of 60 months of training in plastic and reconstructive surgery.
- Involvement in 2500 cases during training including 500 major cases (cases - not procedures).
- Involvement in the full spectrum of plastic and reconstructive surgery provided in the SET program with associated logbook numbers, including 500 major cases in the following categories:
 - Aesthetic
 - Breast
 - Burns
 - CMF
 - General
 - Hand
 - Head and neck
 - Lower and upper limb
 - Paediatric
 - Skin cancer

8. UROLOGY

- Minimum of 60 months of training in urology.
- Include involvement in the order of four operating lists per week for each separate 12 month period over the duration of the training program.
- An operative logbook summary to be provided which includes:
 - the name of each procedure undertaken (and grouped by procedure type – as indicated below); and
 - whether it was open, laparoscopic or endoscopic; and
 - the level of involvement. The level of involvement must note if the involvement in the procedure was either as primary surgeon, secondary surgeon or assistant surgeon.
- Involvement in the following numbers of cases during training (indicative only):

Procedure	Expected no's performed during urology training
TURBT – Resection or diathermy	250
Ureteroscopy (rigid) – biopsy, tumour resection, stone extraction or fragmentation	125
Ureteroscopy (flexible) – biopsy, tumour resection, stone extraction or fragmentation	150
PCNL – biopsy, tumour resection or fulguration, stone extraction or fragmentation	25

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Procedure	Expected no's performed during urology training
TURP / laser prostate, any energy source	150
Open nephrectomy or nephroureterectomy	25
Laparoscopic nephrectomy or nephroureterectomy	50
Pyeloplasty – Laparoscopic or open	10
Partial nephrectomy – Laparoscopic or open	15
Cystectomy or cystoprostatectomy – robotic, laparoscopic or open	25
Radical prostatectomy – robotic, laparoscopic or open	100
Scrotal surgery – exploration, torsion, hydrocele, epididymal cyst, orchidectomy	50
Urethral surgery – excision, urethroplasty, hypospadias, fistula	15

viii) Exposure to the breadth of urological practice including:

- Andrology
- Infection and inflammation
- Male and female urinary tract function
- Oncology
- Paediatric urology
- Trauma
- Upper urinary tract function
- Urinary stone diseases
- Uroradiology

9. VASCULAR SURGERY

- i) Minimum of 60 months of training in vascular surgery.
- ii) Involvement in >600 major vascular cases during training (with > as primary operator).
- iii) Exposure to and competence in the following anatomical areas of vascular practice:
 - Amputations
 - Carotid and subclavian
 - Diagnostic vascular ultrasound (performance and interpretation)
 - Dialysis access and vascular access
 - Endovenous and sclerotherapy
 - Iliofemoral, femoro-popliteal, and tibial/pedal
 - Management of the Complex Diabetic Foot
 - Mesenteric and renal arteries
 - Peri-operative medicine
 - Peripheral endovascular (diagnostic and therapeutic procedures)
 - Sympathectomy and rib resection
 - Thoracic and abdominal aorta
 - Thrombectomy/embolectomy
 - Trauma

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- Upper limb
 - Venous surgery
- iv) Competence in peri-operative management of the vascular patient.
- v) Vascular Ultrasound experience of >100 hours. No more than 20 hours of therapeutic ultrasound (EVLA, ultrasound-guided puncture etc.) will be accepted.
- vi) The expected standard is that the IMG will have performed at least 100 Peripheral Endovascular Therapeutic procedures as primary surgeon and participated in at least 150 cases.
- vii) An operative logbook and logbook summary to be provided the Australasian Vascular Audit (AVA) Operative Logbook Summary template.

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Appendix B: Specialty Specific Requirements for Depth and Scope of Practice

This document defines the standards applied by each surgical specialty in assessing the depth and scope of practice of an IMG to an Australian and New Zealand trained surgeon within the same surgical specialty.

1. CARDIOTHORACIC SURGERY

The IMG's scope of practice in cardiothoracic surgery should be in line with the SET training scope of practice.

The logbook should reach 75% either as assisted or as primary surgeon of the requirement as per regulation. The final logbook assessment is at the discretion of the Board.

2. GENERAL SURGERY

The scope of practice for general surgery is effectively the breadth of surgery included in the MALT logbook for general surgical trainees.

This is a document that has been mostly unchanged over several years but will get modified from time to time.

The IMG should be competent in performing common general surgical emergencies and at least 50% of the elective procedures assessed in the trainee's logbook.

3. NEUROSURGERY

The IMG must have a significant volume of primary operating experience in at least three quarters of the following procedures:

- Cerebral abscess (aspiration or excision)
- Extradural and acute subdural haematomas
- Glioma: High grade - Debulking
- Intracerebral haemorrhage - Evacuation
- Meningioma
- Metastasis
- Posterior decompression
- Revision of shunt
- Spinal cord tumour
- Spinal epidural abscess or tumour
- Spinal fusion: ACDF +/- Plate
- Spinal fusion: Posterior - Instrumented
- Spinal intervertebral disc: Discectomy - Cervical
- Spinal intervertebral disc: Discectomy - Lumbar
- Spinal laminectomy/Laminoplasty for canal stenosis - Lumbar
- Trigeminal microvascular decompression
- Ventriculo-peritoneal shunt

4. ORTHOPAEDIC SURGERY

Similar caseload, responsibility and delegated authority to an ANZ orthopaedic surgeon working in a non-metropolitan public hospital with an emergency department.

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Sufficient training and experience to manage a general orthopaedic trauma scope of practice in a non-metropolitan public hospital with an emergency department.

5. OTOLARYNGOLOGY HEAD AND NECK SURGERY

The scope of practice for otolaryngology head and neck surgery is effectively the breadth of surgery included in the MALT logbook for otolaryngology head and neck surgery trainees.

The IMG should be competent in performing common otolaryngology head and neck surgery surgical emergencies and at least 50% of the elective procedures assessed in the trainee's logbook.

6. PAEDIATRIC SURGERY

The scope of practice for paediatric surgery is effectively the breadth of surgery included in the MALT logbook for paediatric surgical trainees.

The IMG should be competent in performing all common paediatric surgical emergencies and at least 75% of the elective procedures assessed in the trainees' logbook.

7. PLASTIC AND RECONSTRUCTIVE SURGERY

Scope of Practice

4 out of 10 categories required as defined below:

Examples of Major Cases		
1.	Aesthetic	Meloplasty, Rhinoplasty, Body contouring, Massive weight loss
2.	Breast	BRM, BAM, Post mastectomy breast reconstruction
3.	Burns	More than 5% BSA (body surface area)
4.	CMF	Craniofacial, Complex facial fractures
5.	General	Reconstruction of >100 cm ² defect- including pressure sore, abdominal wall, thoracic reconstruction; Major debridement (5% BSA); Completion lymphadenectomy
6.	Hand	Multiple tendon/nerve repair/reconstruction, Fasciectomy, Arthroplasty, complex fractures, carpal stabilisation, tendon/joint reconstruction
7.	Head & Neck	Major Head/neck reconstruction, Parotidectomy, Neck dissection
8.	Lower & Upper Limb (major)	Limb reconstruction excluding just debridement
9.	Paediatric	Cleft lip/palate, cranial vault remodeling, pollicisation
10.	Skin Cancer	Excision requiring major skin grafts/flap reconstruction >100 cm ²

Depth of Practice

- i) Minimum of 500 cases per year (cases - not procedures).
- ii) 100 of 500 cases have to be in the 'major' category as defined by the Board of Plastic and Reconstructive Surgery and IMG Committee. The complex cases have to be fairly evenly spread among a minimum of four of the above categories.

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- iii) Cases may be considered major or minor at the discretion of the IMG Committee and supporting documentation must be available upon request.

8. UROLOGY

- i) Experience in managing the following range of emergency presentations:
- acute lower urinary obstruction with and without obstructive uropathy
 - acute scrotal presentations
 - bladder rupture
 - renal trauma and renal bleeding
 - upper urinary tract obstruction both with and without sepsis
 - ureteric injury
 - urethral trauma
 - urinary tract sepsis
- ii) Experience in managing a majority of the following elective presentations:
- adrenal masses
 - benign prostatic disease and treatment of outlet obstruction
 - bladder dysfunction
 - cutaneous conditions of the penis
 - erectile dysfunction
 - infertility
 - management of abnormal PSA
 - management of haematuria
 - management of reflux
 - management of urological infection
 - PU J obstruction
 - urethral stricture disease
 - urinary incontinence
 - urinary tract calculi (renal, ureteric, bladder)
 - urological malignancy (bladder, kidney, penis, prostate, testis, ureter)
- iii) Operative experience to include:
- minor/intermediate cases - TURBT, ureteroscopy (flexible or rigid), TURP (or equivalent), PCNL, urethral surgery, scrotal surgery;
- and**
- major cases - nephrectomy or nephroureterectomy, partial nephrectomy, pyeloplasty, cystectomy and prostatectomy

9. VASCULAR SURGERY

The scope of practice for vascular surgery is effectively the breadth of surgery included in the AVA logbook for vascular surgical trainees.

The IMG should be competent in performing common vascular surgical emergencies and at least 50% of the elective procedures assessed in the trainee's logbook.

Evidence of this experience during surgical practice is to be provided with an operative logbook and logbook summary using the Australasian Vascular Audit (AVA) Operative Logbook Summary template.

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