THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

ANNUAL REPORT

TO THE AUSTRALIAN MEDICAL COUNCIL

2004

COLLEGE DETAILS:

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1. SUMMARY

Throughout 2004 the College undertook a range of activities to improve its educational outcomes. These included important workshops to review selection and workforce issues within Basic Surgical Training and Specialist Surgical Training (formerly known as Advanced Surgical Training). These workshops involved a variety of stakeholders including surgeons and senior Jurisdictional Representatives. Further details on the outcomes of these workshops can be found in this report.

The College is increasing its use of the College website, at www.surgeons.org, for online curriculum access and dissemination of information. The use of the website is a feature of College development and allows both trainees and Fellows immediate access to the latest information, policies and curriculum materials. The website will also become a primary source of information for any interested party to review information pertaining to any external reporting requirements. A report on the activities of the College for the 2003 year and January to June 2004, which addresses the conditions of the ACCC determination on the College, has already been posted on the website.

In 2004 the College made strides in developing new policies and formalising existing policies across all Divisions of the College. Policies that have been approved within Basic Surgical Training and Specialist Surgical Training can be viewed on the College website under "About Us"

In 2004 there were two Review Committees established by the Australian Competition and Consumer Commission to examine and report on College activities in regard to the Assessment of Overseas Trained Doctors and the Accreditation of Hospitals for Basic Surgical Training and Hospital Posts for Specialist Surgical Training. At the time of writing this report the College has received the draft final reports and recommendations from the two Review Committees and has prepared responses to the proposals within those draft final reports.

This Annual Report addresses specific questions raised by the Australian Medical Council, elaborates on the proposed direction of the College across a range of areas and activities and provides qualitative and quantitative details of all College activities.

The content of this report will be incorporated into the College's annual operational report for 2004.

Strategic Organisational Improvements in 2004

A Dean of Education was appointed to the College in August 2004 to provide educational advice and strategic policy leadership, to collaborate closely with the Censor in Chief and the Chairs of the various College Boards, and to represent the College on key external groups relating to surgical education. Since commencing his appointment the Dean has provided leadership in undertaking these activities, and also in the assessment of Overseas-Trained Doctors, the development of curricula, surgical competencies and aligned assessment, and redefining accreditation criteria for hospitals and posts.

A Censor in Chief's Decisions Review Committee was created to deal with complaints more effectively within the Education portfolio. The Committee has both reconsideration and review processes for dealing with complaints before they reach the formal appeals mechanism.

The Division of Academic Services was divided into the division of Basic Surgical Training and Skills and the Division of Specialist Surgical Training and Assessment. The two divisions now give better service to Basic Surgical Trainees, Specialist Surgical Trainees and Overseas-Trained doctors by focussing resources and expertise within these more specialised Divisions.

2. EDUCATION - BASIC SURGICAL TRAINING

2.1 SELECTION AND TRAINEES

Provide a brief summary of significant changes planned or implemented:

- *To the policy and procedures for trainee selection.*
- *To the College's role in selection.*
- *To arrangements for trainee support and counselling and/or mentoring programs.*

Provide details of actions planned or taken by the College to ensure that selection policies and practices comply with principles in the 1998 report "Trainee selection in Australian Medical Colleges" by the Medical Training Review Panel (Brennan Principles).

2.1.1 Selection policies and procedures

There have been no changes to the processes for the selection of Basic Surgical Trainees in 2004.

Following the 2004 selection round for the 2005 intake for Basic Surgical Training (BST), the College conducted a workshop on Wednesday 17 November 2004. The broad aims of this workshop were to seek input from the Jurisdictions regarding the methodology of the allocation of Basic Surgical Trainees and to discuss other issues relating to BST and articulation of trainees into Specialist Surgical Training.

Attendees included Board of BST members, Jurisdictional Representatives, Representatives from the Post Graduate Medical Councils, Representatives from other National Bodies, Chairs of various College Boards and College personnel.

Following constructive and detailed discussion it was agreed to implement an "Eight Point Plan" comprising of the following principles

(i) Jurisdictions with advice of AMWAC and College establish workforce requirements,
(ii) SST positions, needing to be funded and accredited, to be recognised by the Jurisdictions and the College,
(iii) BST intake each year, aligned with AST entry numbers, be agreed by Jurisdictions and the College,
(iv) College with advice of the Jurisdictions to establish criteria for selection / eligibility,
(v) College with appropriate jurisdictional involvement to run national selection / eligibility process,
(vi) Jurisdictions develop a national allocation methodology (for States and Territories) for the BST trainees,
(vii) Jurisdictions establish administration of trainee allocation and appointment process to health services in consultation with College
(viii) The model to properly incorporate New Zealand workforce and training imperatives. (Note: i.e. a model to reflect appropriate aspects of points 1 – 7 be developed to address the long term workforce requirements of NZ and the annual intake of trainees for NZ)

Details of the implementation of the Eight Point Plan will be confirmed by April/May 2005 prior to the next selection round. Its implementation will affect the methodology by which trainees are distributed with this responsibility transferred from the College to Jurisdictions. The Plan has further significance in being indicative of improved collaboration between the College, AHWOC and the Jurisdictions in the determination of trainee numbers.

Any actions taken by the College or other relevant organisation to address any disparities between the number of applicants and training opportunities

This issue is addressed in subsequent sections of this report.

2.1.2 Role of the College

Provide a short summary of the activities of and significant issues raised by the trainees' association, if one exists.

The Education Policy Board has proposed to the College Council the establishment of a Trainees' Association and a Trainee Advocate and this will be progressed in 2005.

There is provision for two trainees to participate in the Curriculum Review Committee of the Board of Basic Surgical Training. These trainees have been selected on an annual basis between the Australian States and New Zealand. Basic Surgical Training has an on line forum whereby trainees are able to contact each other as well as the College. There are also trainee representatives on the Board of Specialist Surgical Training.

Summarise any issues that were raised by trainees

A need has been identified to develop a tiered approach to the resolution of issues arising from decisions made by the College, before they proceeded to formal appeal. Issues progress to the formal level of appeal at significant cost to the appellants and the College. These issues would be more efficiently dealt with at a less formal level by senior Fellows in the education portfolio. The College has therefore developed a "reconsideration and review process" to better handle concerns about decisions made within the Education portfolio. Under this policy, decisions to which challenges are made will first be reconsidered by the body that made the original decision. If that body upholds its original decision the matter will then be reviewed by the Censor in Chief's Decisions Review Committee. If that Committee upholds the decision and the trainee remains aggrieved then the trainee may wish to proceed with a formal appeal. A similar "reconsideration and review process" is known to operate well for other Australasian Colleges.

2.1.3 Selection outcomes

Provide information on the number of trainees entering training programs (if applicable, provide figures for basic and Specialist training programs). If the College has identified a disparity between the number of training posts/opportunities available and the number of applicants for the positions, please comment briefly on the reasons for this disparity and any actions by the College and other bodies to address it.

In Basic Surgical Training the total intake for 2004 was 205. In New Zealand the intake was 37. The intake in Australia was 168. Distributed across the following States:

Table 2.1 Trainee intake for Australia, Basic Surgical Training, by region (2004)

Australian Capital Territory	4
New South Wales	52
Northern Territory/South Australia	17
Queensland	25
Tasmania	5
Victoria	48
Western Australia	17

2.2 TRAINING

Provide details of any changes to the education and training programs and any significant changes planned within the next 12 months, together with a brief statement of reasons and evidence for the change. This should include changes to:

- *The goals of education and training.*

The College is committed to ensuring the highest standard of safe and comprehensive surgical care for the communities we serve through excellence in surgical education, training, professional development and support. A specific focus of the College is to train surgeons to the point where they are competent to practice independently and safely in a wide range of settings and provide the highest standards of care to their patients.

To facilitate this, the College has focussed on the enhancement of curriculum materials including the definition and application of surgical competence within all of its programs. As part of that process the College is continuing to develop explicit definitions about the levels and range of competencies required at the completion of Basic and Specialist Surgical Training.

The College is also working with a number of Federal Government departments and working groups to identify the goals of surgical education and training and the needs of particular groups of surgical trainees and specialists. The RACS definition of Competence was accepted by the Chief Medical Officers Medical Specialist Taskforce as a basis for the development of a framework for training of all medical specialists in the future. Following the successful completion of the work of the Medical Specialist Training Taskforce in 2004 the College is continuing to work with the Medical Specialist Training Steering Committee in defining educational needs, training requirements and learning environments for medical specialist training

- *Structure and duration of training.*

There have been no changes to the structure and duration of the training programs during 2004.

- *Content of education and training program.*

There have been no changes to the content of the training program. The training program may be viewed on the College website under Education - Surgical Education and Training Handbook.

Under the direction of the Federal Government, the College through the Skills Laboratory Working Party is the agent in the development of an Eastern Seaboard Masterplan for Skills Laboratories (Masterplan). The aim of the Masterplan is to ensure that the best possible linkages exist between eastern seaboard skill centres and to form a framework through which to accommodate the training needs of all medical and allied health professionals.

Stage one of the development has been completed with the submission of a scoping document in September, 2004. The final Masterplan document will be submitted by 31st May 2005.

2.2.1 Supervisors, Assessors, Trainers and Mentors

Provide details of any significant changes to the process by which supervisors are appointed and/or to the roles of supervisor, assessors, trainers and/or mentors.

There have been no changes to the processes for the appointment of supervisors or the roles of the assessors or trainers.

Provide details of any significant activities to support supervisors, assessors, trainers and mentors, such as training activities or written manuals.

The College updated the “Surgical Education and Training Handbook” (SETH) which may be viewed on the College website under Education. The Handbook outlines the duties of supervisors and other areas that supervisors could find useful.

It is planned that the information about supervision, training and mentoring will be revised during 2005 in order to more clearly articulate the link between training experiences, the development of the RACS competencies, assessment processes and the expectations of supervisors, trainers and mentors.

During 2004 the College developed policies which are being made available on the College website as they are approved. This process will continue throughout 2005. Recently revised policies include:

- Policy and Procedure for Identification and Management of Academic Misconduct
- Interruption of Training
- Full-time Training
- Trainee Registration Status of Surgical Trainees
- Deferral of Surgical Training
- Part-time Training
- Transitional Surgical Trainees in 2005
- Fee Payment for Deferral
- Fee Payment when Deferral is Reversed

The College conducted two "Surgical Teachers" courses with a total of 39 Fellows participating in Adelaide and Perth. The courses are designed to improve the skills and knowledge through modules on adult learning, teaching skills, feedback and assessment

Two Early Management of Severe Trauma (EMST) instructors' courses and one Care of the Critically Ill Surgical Patient (CCrISP) instructors' course were held in 2004. This resulted in a total of thirty nine new instructors. The courses were aimed at improving skills in the general area of teaching and with specific relationship to the delivery of the set curriculum of these programs.

2.2.2 Facilitated Personal Mentoring Scheme

In July 2001 the College implemented a Facilitated Personal Mentoring Scheme for trainees in the restructured Basic Surgical Training Programme. The focus of the scheme is to provide trainees in the restructured basic surgical training programme with an opportunity to enhance their educational experience by having access to a personal mentor. The Scheme was implemented as a result of the findings from a pilot study that was conducted by the Women in Surgery Group of the College. The pilot study was conducted with female trainees only however the results of the pilot study indicated that the scheme would be beneficial to all trainees in the training programme.

Approximately 60 pairs remain in contact from the 2001-2003 cohorts of trainees registered in the scheme. In 2005 a review will be undertaken to investigate alternative facilitation models for mentoring relationships.

2.3 EVALUATION OF THE PROGRAM

Provide details of any significant changes to the way in which the college monitors and evaluates the quality of its education and training programs and/or to methods used to monitor the trainees' and the supervisors' opinion of the programs.

Provide information on the following activities undertaken in the last 12 months:

- *new evaluation activities initiated*
- *evaluation activities completed*
- *changes in the resources available to support the program.*

The College recognises the importance of evaluating programs and processes. All evaluation activities are mapped to ensure that they address major priorities of the College which have been identified in the College Strategic Plan. Key evaluation questions have been identified through this mapping process. The Dean of Education, a Fellow of the College appointed in mid 2004, has been involved in this process.

The Evaluation Co-ordinator has provided support in strategic planning by identifying and initiating specific projects related to the evaluation of the education and training programs. The Evaluation Co-ordinator has also been working on developing robust systems for the collection, recording and reporting of training data, including trainee cohort data and improved methods for collecting and reporting trainee assessment data.

One early outcome of these evaluation activities was the recognition that the Basic Surgical Training objectives need to be aligned with the RACS competencies (see Appendix 1, adapted from the CanMEDS). This will be a priority project to be carried out early in 2005. Mapping the BST objectives to the RACS competencies will provide the benchmarks for effective evaluation of all the components and activities of the BST Programme.

In December 2004 the College appointed a Curriculum Developer for Basic Surgical Training to work with BST Boards and with the Evaluation Co-ordinator. With three staff now involved in evaluation this aspect of College work will progress.

2.4 ASSESSMENT

2.4.1 Assessment policies and procedures

Provide details of any significant changes to assessment and examination policies and practices and any changes planned within the next 12 months, together with a brief statement of reasons and evidence for the change, including:

- *Changes to assessment policy and principles.*

In the Basic Surgical Training MCQ examination the College has implemented the Rasch Model.

The Rasch Model is a method of constructing tests. It provides a theory for (1) item analysis and selection, and (2) a measurement scale for reporting scores. The Rasch Model states that the probability of a person answering correctly a test item is a function of two attributes or parameters:

i) The *person* attribute – theoretically any trait of interest in the measurement situation but most often "ability, achievement and aptitude". More specifically it is the amount of such a trait the person possesses to answer correctly a certain number of items like the ones on a given test.
ii) The *item* attribute – in effect the difficulty level defined as that point on the ability scale where the person has a fifty percent chance of answering the item correctly.

As a result the Rasch model puts people and test items on the same scale. The estimation of these two attributes – person ability and item difficulty – is termed calibration. Therefore the Rasch Model tests the ability of the person in relation to the examination rather than in relation to each other person undertaking the examination as exists under the normal curve equivalent.

In addition to the introduction of the Rasch model, further work was undertaken by the Board of Basic Surgical Training throughout 2004 to develop a process for determining a criterion referenced pass standard for the MCQ examination. A criterion referenced pass standard is pre-determined and objective (i.e. not relative) and is set at a level that demonstrates competence in basic sciences. The criterion reference pass standard will replace the interim derived pass

standard in June 2005. The name of the examination will be changed to Basic Sciences Examination to better reflect the subject matter of the examination.

- *Changes to assessment to reflect changes in educational objectives and/or learning goals and methods.*

Extended matching questions are available on-line for Basic Surgical Trainees to use for self-assessment.

The initiatives introduced to determine outcomes/outputs

This is largely answered throughout the report as initiatives are introduced to enhance surgical training overall.

2.4.2 Assessment outputs and outcomes

Provide information on the following since the last report:

- *The components of summative assessment and the number of candidates sitting and passing each component each time they were held. If applicable, comment briefly on actions taken by the College in response to significant changes in the percentage of candidates passing summative assessments.*

Table 2.2 Assessment outputs and outcomes for Basic Surgical Training (2004)

MCQ

	Candidates presented	Candidates passed	Pass rate (%)
February	67	37	55
June	98	52	53
November	90	45	50
2004	255	134	53

Clinical Examination (formerly OSCE)

	Candidates presented	Candidates passed	Pass rate (%)
February	104	101	97
July	91	87	96
2004	195	188	96

2.5 ACCREDITATION OF HOSPITALS

Provide a brief statement of any significant developments in the College's relations with the State, Territory or New Zealand health care services.

The College has been working for some time on improving its accreditation processes and criteria of the various hospitals and posts used to train surgeons. Suggestions made by the AMC review and more recently by the ACCC review are being incorporated with those developed by the College. The agreed outcome for Basic Surgical Training is to produce a trainee surgeon able to progress satisfactorily to Specialist Surgical Training. For Specialist Surgical Training the aim is to produce a safe and competent surgeon who can practice independently and has received the preparation needed to work in different hospitals, locations and practice settings.

The College goal is to ensure that its accreditation standards, criteria and processes are objective, transparent, justified and clearly documented. Work is progressing on producing these goals with input from relevant stakeholders, including jurisdictions, health services, accredited hospitals and trainees.

During 2004 there was a substantial increase in the representation of the jurisdictions on Committees and Boards at all levels of the College management structure, including hospital and post inspections, the Board of Basic Surgical Training, the Board of Specialist Surgical Training, the Education Policy Board, and selection workshops, all of which dealt with issues of hospital and post accreditation.

Jurisdictional Representatives are invited to attend all hospital and hospital post inspections and are full participating members of those teams. The inclusion of the Jurisdictional Representatives has resulted in a mutually increased understanding and appreciation of the preferred outcomes of the accreditation processes on the part of the College and the jurisdictions.

Provide details of any significant changes to arrangements for the accreditation of training programs, institutions or training posts such as:

- *Changes to accreditation policy or principles.*
- *Changes to the criteria for accreditation.*

Major work is currently underway on this topic and will be reported in the 2005 AMC report.

Provide a short report on the developments concerning trainee clinical experience, such as

- *Access to outpatient and ambulatory experience*
- *Mechanisms for monitoring the adequacy, supervision and organisation of clinical placements.*
- *Changes to the range of hospitals/institutions accredited for training.*

The College has responded to the ACCC Review Committee draft report on the Accreditation of Hospitals for Basic Surgical Training and Hospital Posts for Specialist Surgical Training. Pending the final report being received, there is likely to be some recommendations which may affect the clinical placements of trainees.

3. EDUCATION - SPECIALIST SURGICAL TRAINING

3.1 MEMORANDA OF ASSOCIATION AND SERVICE AGREEMENTS WITH THE SPECIALTY SOCIETIES AND ASSOCIATIONS

The roles of the College and specialty societies and associations in surgical education and training have been undergoing change during 2004. Specialty Service Agreements assigning responsibilities for education and training were signed in late 2003 and early 2004 by 12 societies representing the nine specialties in Australia and New Zealand. Of the 13 recognised societies and associations only General Surgeons Australia (GSA) has not signed an agreement with the College due to representation and legal structure issues.

Surgical education and training is now delivered through six service activities which are split between the College and the specialty society. These activities are:

- Course Development
- Trainee Selection
- Hospital Post Accreditation
- Course Delivery
- Records Management
- Program Management

The societies/associations and the College discuss which tasks each will take responsibility for. Increasingly, the role of the College is to ensure that all aspects of the surgical training programs comply with accreditation and authorisation requirements.

Pooling Australia/NZ training fees, the Service Agreements have three funding components:

(i) College Component – covering estimated overhead costs to the College.

(ii) Base Services Component – this has four subcomponents, with societies being funded for representation at the BSST, conduct of the Specialty Board, general office expenses for training matters and a Board Chair's budget.

(iii) Service Activity Component – the pool of AST funds, after deduction of the College and Base Components, is distributed between the societies and the College, based on who performs each of the six activities. Where a society performs all six of the service activities, it is entitled to 100% of the available "per trainee' service activity fee. Where selected activities are performed, they are entitled to an agreed percentage of the fee.

Table 3.1 Activities undertaken by each society/association.

Society*	Course Development	Trainee Selection	Post Accreditation	Course Delivery	Records Management	Program Management
GSA	N	N	N	N	N	N
NZAGS	N	N	N	Y	N	Y
AOA	Y	Y	Y	Y	Y	Y
NZOA	Y	Y	Y	Y	Y	Y
NSA	Y	Y	Y	Y	Y	Y
ASPS	Y	Y	Y	Y	N	Y
NZAPS	N	N	N	N	N	N
ASCTS	N	N	N	N	N	N
AAPS	N	N	N	N	N	N
USA	Y	Y	Y	Y	Y	Y
ASOHNS	N	N	N	Y	Y	Y
NZSOHNS	N	Y	N	Y	Y	Y
ANZSVS	N	N	N	N	N	N

According to the terms of the Service Agreement the party taking responsibility for any activity must do so for the entire activity; unless there are exceptional circumstances there shouldn't be sharing of activities. The College undertakes those activities not undertaken by societies.

* Abbreviations for the Societies and Associations:

GSA - General Surgeons Australia; NZAGS - New Zealand Association of General Surgeons; AOA - Australian Orthopaedic Association; NZOA- New Zealand Orthopaedic Association; NSA - Neurosurgical Society of Australasia; ASPS - Australian Society of Plastic Surgeons; NZAPS, New Zealand Association of Plastic Surgeons; ASCTS Australian Society of Cardiac and Thoracic Surgeons; AAPS Australasian Association of Paediatric Surgeons; USA- Urological Society of Australasia; ASOHNS - Australian Society of Otolaryngology - Head and Neck Surgeons; NZSOHNS - New Zealand Society of Otolaryngology - Head and Neck Surgeons; ANZSVS - Australian New Zealand Society of Vascular Surgeons.

3.2 SELECTION AND TRAINEES

3.2.1 General Training Principles and Policies

The College selection processes are based on the principles outlined in the 1998 report, 'Selection into specialist Training Programs' by the Medical Training Review Panel (Brennan Principles).

Update on developments during 2004-5
Significant changes in the following areas:

- *policy and procedures for trainee selection*
- *College's role in selection*
- *arrangements for trainee support and counselling and/or mentoring programs*
- *summary of the activities of and significant issues raised by the trainees' association*
- *information on the number of trainees entering training programs.*
- *statistical data on the disparity between the number of training posts/opportunities available and the number of applicants for the positions, including reasons for the disparity, and any actions taken by the College and other bodies to address this*

Trainees apply in open competition to Advanced Surgical Training and selection is undertaken according to the Brennan Principles. The College runs training workshops for those involved in selection.

In October 2004 the Board of Specialist Surgical Training conducted a workshop at the College to discuss the principles and processes of selection. Attendees included the Censor-in-Chief, representatives of the Court of Examiners, Chairs of the Specialty Boards, the Dean of Education, the College legal advisor, and jurisdictional representatives from the Specialty Boards. The workshop covered all aspects of the selection process and the expected criteria to be used by all specialties.

Each of the Boards of Specialist Surgical Training annually review their selection processes and produce a report. These reports form the basis of reviews conducted prior to the subsequent year's selection to continuously refine the process.

The College is collaborating with the jurisdictions to ensure effective inclusion of jurisdictional representatives on all College selection panels.

In 2004 the College ran a series of 7 interviewer training workshops in Australia with a total of 116 Fellows attending. These workshops were designed to enhance the interview skills of Fellows on trainee selection panels for both Basic and Specialist Surgical Trainee selection. Attendees were provided with a training manual for subsequent reflection and reference. The workshops were well attended and feedback from the Fellows was very positive.

The interviewer manual was revised in 2004 to ensure that it remains up-to-date with the most current selection principles and practices.

3.2.2 Activities of trainees and significant issues raised by the trainees

Feedback from trainees is received through a number of avenues. The Board of Specialist Surgical Training appoints two trainee representatives who are able to raise and discuss issues of concern to trainees. The Australian Orthopaedic Registrars Association is an avenue for orthopaedic trainees to raise issues related to training in general or specific to the Orthopaedic Surgery training program.

Each Specialty website contains a forum for trainees to conduct and/or participate in their own forum. During 2005 this facility will be promoted amongst the trainees in each of the specialty groups.

The College has developed a "reconsideration and review process" to better handle concerns about decisions made within the Education portfolio, as described earlier for Basic Surgical Training.

Concerns have been voiced, by new graduates from medical school who are contemplating a career in surgery and by some Basic Surgical Trainees, about the disarticulation between Basic Surgical Training and Specialist Surgical Training. The College has also recognised that surgical training must become seamless and the Educational Policy Board has made a recommendation to Council that this be implemented. Issues of work-life balance, safe hours and perceived communication problems with the College have also been raised and are being addressed.

3.2.3 Trainees' Association

At present there is no RACS trainees association and trainee representation is performed by the Australian Medical Association, specifically Doctors in Training. The College liaises regularly with the AMA to ensure that trainees' needs are addressed. The College encourages trainee representation on its major Boards and Committees and in February 2005 the College Council agreed to progress the establishment of a Trainee Association and a Trainee Advocate. The College is exploring options to facilitate the formation of a trainee representative organisation and is currently reviewing the Canadian and UK models.

3.2.4 Statistical Data on Selection into Specialist Surgical Training

In Specialist Surgical Training the total intake for 2004 was 232. In New Zealand the intake was 34. In Australia the intake was 198, distributed across the Surgical Specialties as follows:

Table 3.2 Intake by Surgical Specialty for Australia, 2004

Cardiothoracic Surgery	4
General Surgery	95
Neurosurgery	16
Orthopaedic Surgery	40
Otolaryngology Head and Neck Surgery	16
Paediatric Surgery	1
Plastic and Reconstructive Surgery	13
Urology	12
Vascular Surgery	1

3.2.5 Disparities between the number of applicants and training opportunities

Due to ongoing concerns about trainees who may have been disadvantaged by recent changes in the structure of Basic Surgical Training and articulation to Specialist Surgical Training, the

additional category of selection for trainees, the “Transitional Surgical Trainee” (TST), was incorporated for 2004.

The College Council agreed on the following definition of a TST. “A 2004 TST is an applicant who has met the eligibility and selection criteria as outlined by the Specialty Boards and whose application was unsuccessful due to the limited number of available training positions, but would be permitted another application to Specialist Surgical Training in 2004 for entry to training in 2005. Trainees who did not meet the requisite criteria would no longer be eligible to apply to Specialist Surgical Training”.

The College has recently decided to extend the TST arrangements until such time as sufficient accredited AST positions have been established to meet projected workforce requirements. It has also been decided that TSTs may apply to all AST specialties in 2005. There are 35 people offered 2005 TST status (of whom 27 have registered), and 20 who were offered the opportunity to extend their 2004 TST status (of whom 4 have registered).

The growing number of TSTs is an issue of grave concern to the College. These BST graduates are unable to progress their surgical education and training due to the lack of appropriate Specialist Surgical Training posts.

3.3 TRAINING

The specialist surgical curricula:

- *enable trainees to achieve goals of the training program*
- *specify the educational objectives for each component*
- *provide details of the nature and range of clinical experiences required to meet the learning objectives*
- *outline the syllabus of knowledge, skills and professional qualities to be acquired*

The College’s processes determine the broad roles of practitioners in each surgical discipline. These roles are addressed by the objectives of the training programs.

Developments during 2004-5

Changes to the education and training programs and any significant changes planned within the next 12 months, together with a brief statement of reasons and evidence for the change in the following areas:

- *the goals of education and training.*
- *structure and duration of training.*
- *content of education and training program.*
- *formal educational courses.*
- *changes planned to the range of education and training programs in sub-specialties.*

3.3.1 Goals of Education and Training

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

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

3.3.2 The Curriculum

Since 2001 the College has systematically reviewed the curricula for each specialty. The RACS "Definition of Surgical Competence" (Appendix 1) was accepted by the Chief Medical Officers Medical Specialist Taskforce as a basis for the development of a framework for training of all medical specialists in the future. Following the successful completion of the work of the Medical Specialist Training Taskforce in 2004 the College continues to work with the Medical Specialist Training Steering Committee to define educational needs, training requirements and learning environments for medical specialist training in Australia.

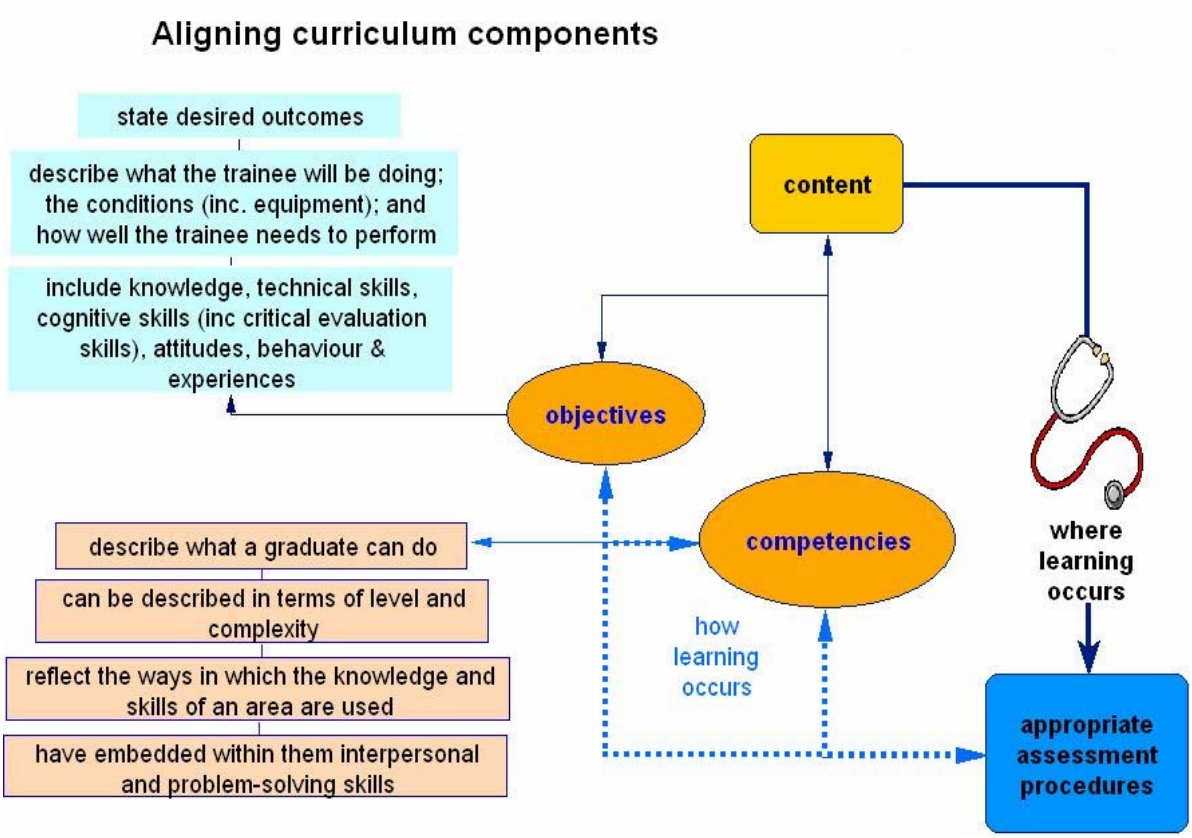
An extensive review of the General Surgery training program has taken place. The program, which included three years of broad training in General Surgery followed by two years of more specialised training, was replaced by a four-year programme. Arrangements were put in place to ensure that those on the old program were not disadvantaged in any way.

The Specialist Surgical Training online curriculum includes clearly articulated learning objectives and competencies, an explanation of the philosophy and goals of the training courses and learning materials for self directed learning. Curriculum maps for most of the specialty areas have been developed to provide an overview of the entire specialist surgical training curriculum and to facilitate the linking of assessment and content.

Figure 3.1 presents diagrammatically the various components of surgical training and is broken into three stages that are linked:

a. Objectives - shaded in light blue
b. Competencies – shaded in orange
c. Assessment – shaded in dark blue

Figure 3.1: Aligning curriculum components.



The College has well developed content and assessment for training (see the dark blue lines in Figure 3.1 which connect content with assessment). However, the aim of more recent curriculum development has been to develop clearly articulated learning objectives, objectives

regarding what the trainee should be able to do, and competencies necessary to practise as an independent specialist in the Australian and New Zealand health systems.

This requires two further levels of curriculum development. The first is to link content with objectives and desired competencies (thin blue line in Figure 3.1). The second is to gain a better understanding of how learning occurs, which requires linking competencies, objectives and appropriate assessment procedures (blue dotted line, Figure 3.1).

Since the adoption of the RACS Statement of Surgical Competency (see Appendix 1) each specialty has been developing a specialty specific competence statement which is then used as a basis for the development of educational and training resources. Table 3.3 provides an overview of curriculum development by specialty.

3.3.3 Curriculum development

Formal educational courses

Orthopaedic Surgery has introduced a one day training course on “Radiation Safety in Orthopaedic Surgery”.

Initiatives in surgical education and training

During 2004 the College thoroughly investigated a proposal for a Joint Fellowship program with the Royal Australasian College of Dental Surgeons (RACDS) for training in Oral and Maxillofacial Surgery. After extensive discussion College Council decided that the development of the conjoint Fellowship should not be pursued.

Negotiations have continued between the two Colleges to determine a suitable and appropriate agreement whereby trainees of the RACDS would have access to appropriate training modules of the College Basic Surgical Training program. It is envisaged that agreement will be reached sometime in 2005.

Table 3.3 Progress on curriculum development by Surgical Specialty.

Specialty	**Learning objectives clearly stated**	**Defined surgical competencies for each subject area**	**Curricula published on College website**
Cardiothoracic	To be commenced 2005	To be commenced 2005	To be commenced 2005
General	Completed	Completed	Completed 2004
Neurosurgery	Completed	Completed	Completed 2004
Orthopaedics	To be commenced 2005	To be commenced 2005	To be commenced 2005
Otolaryngology	Completed	Completed	To be released June 2005
Paediatrics	Completed	In progress	To be released progressively during 2004/2005
Plastics & Reconstructive	Completed	Completed	To be released March 2005
Urology	Completed	Completed	Completed 2004
Vascular	In progress	In progress	To be released progressively during 2004/2005

3.3.4 Outer Metropolitan Specialist Training Program

Some surgical procedures are only provided through the private sector. Consequently the College has been exploring such opportunities for training. In 2004, the College participated in the federally funded “Outer Metropolitan Specialist Training Program”, which was designed to provide Specialist surgical trainees with the opportunity to undertake training in the private sector.

Initially the program had a target of up to 20 placements; however, due to program restrictions there has been limited uptake. A significant limiting factor was the geographic definition of "outer metropolitan". As there are few hospitals in outer metropolitan regions with the infrastructure necessary to support surgical training, opportunities were severely restricted. The time restriction of Commonwealth funding for one year has also restricted the ability for this program to increase the total number of Specialist Surgical Trainees, which remains a minimum 4 year training program.

Three new posts were identified and accredited under the Outer Metropolitan Specialist Training Program - two in Urology, at Greenslopes Private (Brisbane) and Hollywood Private (Perth), and one in General Surgery at Hawkesbury District Health Service (Sydney).

3.4 SUPERVISORS, ASSESSORS, TRAINERS AND MENTORS

General Training Principles

- *selection and training of supervisors*
- *systematic process for trainee feedback*
- *obtaining confidential reports from trainees on quality of their supervision, training and clinical experience*
- *selection of assessors with demonstrated relevant capabilities in:*
    - *written*
    - *oral and*
    - *performance based assessment and examination*
- *training programs in consistent assessment methods*
- *mentor program*

Update on developments during 2004-5

- *Changes to the process by which supervisors are appointed and/or to the roles of supervisor, assessors, trainers and/or mentors.*
- *Activities to support supervisors, assessors, trainers and mentors, such as training activities or written manuals.*

3.4.1 Appointment of supervisors, Roles of the assessors and trainers

There have been no changes to the processes for the appointment of supervisors or the roles of the assessors or trainers. As in other years, assessors and examiners are encouraged to attend "Surgeons as Educators Workshops" and "Interviewer Training Workshops".

3.4.2 Training policies and manuals

During 2004, the College revised its "Interviewers' Training Manual". During 2005, it will develop a manual for all assessors and examiners that will include the following:

- Description of the assessment processes used by the College
- Overview of assessments methods and tools used by each specialty
- Descriptions of the role and responsibilities of assessors, senior examiners and members of the Court of Examiners
- Policies relating to assessment are being revised and published on the College website. Policies recently revised that related to assessment were:
    - Policy and Procedure for Identification and Management of Academic Misconduct
    - Interruption of Training
    - Full-time Training
    - Trainee Registration Status of Surgical Trainees
    - Deferral of Surgical Training
    - Part-time Training
    - Fee Payment for Deferral
    - Fee Payment when Deferral is Reversed

Representatives of the College have planned a visit in 2005 to the Royal College of Physicians and Surgeons of Canada to discuss a range of educational issues, including methods for obtaining systematic process for trainee feedback and confidential reports from trainees on the quality of their supervision, training and clinical experience, and options for appointment of a trainee advocate.

Urology have been planning to introduce a confidential trainee evaluation of their experience within each rotation to be sent to the Board of Urology and fed back to the hospital as part of the accreditation process.

Office Bearers and staff of the College have been invited to participate in an AMC-CPMC Workshop in 2005 on linking assessment with curriculum.

The College has arranged an assessment Workshop that will address a range of issues, including linking curriculum to assessment, and which will be attended by members of Specialty Boards, the Court of Examiners and the Jurisdictions.

3.5 OUTPUTS AND OUTCOMES OF TRAINING

During 2004-5 the College introduced an electronic data collection system, which will be used to provide statistical data for formative and summative assessment and examinations. In 2005 the College will also install a database for the management of question banks, and the design and delivery of examinations. This database will provide statistical data on performance of individual examination questions.

3.6 EVALUATION OF THE PROGRAM

AMC Requirements for Accreditation:

Processes for the regular evaluation and review of its training programs
Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to these processes

Update on developments in 2004-5

- *Details of significant changes to the way in which the college monitors and evaluates the quality of its education and training programs and/or to methods used to monitor the trainees' and the supervisors' opinion of the programs.*
- *Activities undertaken in the last 12 months:*
  - *new evaluation activities initiated*
  - *evaluation activities completed*
  - *changes in the resources available to support the program.*

In 2004 major activities in evaluation took place in concert with the ACCC Reviews of the Accreditation of Hospitals and Posts and the Assessment of Overseas-Trained Doctors. Final reports on both reviews will be published March/April 2005. For details relating to these reviews see the relevant sections of this report. In 2004, the College appointed a Dean of Education and an Evaluation Coordinator to oversee evaluation activities as listed in the College's "Strategic Plan for Education.

Based on initial discussions about priorities it has been decided to pay specific attention to the following evaluation activities:

- development of robust systems for the collection, recording and reporting of training data, including trainee cohort data
- improved methods for collecting and reporting trainee assessment data
- development of mechanisms to gain regular feedback from trainees and supervisors regarding the evaluation process
- audit the Fellowship Examination
- detailed analysis of repeated examination failure.

3.7 ASSESSMENT

The College principles for assessment of trainees are as follows:

- *systematic program of formative and summative assessments, which are demonstrated to be valid and reliable.*
- *assessment program reflects comprehensively the educational objectives of the training program.*
- *Processes for early identification of trainees who are under performing and for determining programs of remedial work.*

Developments in 2004-5

- *Changes to assessment and examination policies and practices during 2004*
- *Planned changes planned for 2005 with a brief statement of reasons and evidence for the change, including:*
  - *Introduction of new methods of formative and/or summative assessment.*
  - *Changes to assessment to reflect changes in educational objectives and/or learning goals and methods.*
  - *Changes to the process for identifying unsatisfactory performance by trainees.*
  - *The initiatives introduced to determine outcomes/outputs*
  - *Provide information on the following since the last report on the components of summative assessment and the number of candidates sitting and passing each component each time they were held. If applicable, comment briefly on actions taken by the College in response to significant changes in the percentage of candidates passing summative assessments.*

3.7.1 Types of Assessment

The College has introduced several forms of formative assessment during 2004 and is exploring ways to introduce multiple forms of assessment that will assist in translating learning into the clinical environment (Table 3.4). Specialty Boards are continuing to review their assessment in light of trainees' changing educational experiences prior to commencing surgical training, the changing knowledge and skill requirements within the training program (including competencies), and changes in the clinical environment.

In particular the teaching and learning of Anatomy for both Basic and Specialist Surgical Training has been the focus of attention and a working party will report on this shortly.

a Adapted 360° Rating Scale

Orthopaedic Surgery initiated the use of these rating scales and several other Surgical Specialties are exploring their use or have already adopted this practise.

General Surgery has introduced a mid-term assessment process to facilitate the early identification of unsatisfactory performance by trainees and to provide opportunities for trainees to improve their performance.

b Specialty-Specific Principles and Basic Sciences

There are many benefits to trainees of understanding early in their specialty training, the important principles and relevant basic science which underpins that specialty. For this reason some specialties have introduced a curriculum which includes an examination at the end of the first year of specialty training, and others are contemplating doing so. Orthopaedic Surgery and Plastic and Reconstructive Surgery see this as a hurdle examination, whereas Paediatric Surgery considers it to be a component of the Fellowship Examination.

c Logbooks and Trainee Evaluation Forms

The publishing of surgical competencies has lead to changes being made to trainee logbooks, (which record the details of a trainee's clinical experience), to ensure they reflect the defined surgical procedures. Trainee Evaluation Forms are being aligned with the surgical competency statements. It is intended to expand the on-line materials to include all nine specialties during 2005.

d Written Examinations

Short answer questions are used by several specialties and discussion is taking place on improved ways to mark them. Some international assessment bodies use computer marking for such questions. General Surgery has replaced its MCQ examination with Spot Questions and is encouraged by its initial experience.

Table 3.4 Forms of Assessment in Specialist Surgical Training, by Surgical Specialty.

Specialty	**Cardiothoracic**	**General**	**Neurosurgery**	**Orthopaedics**	**Otolaryngology**	**Paediatrics**	**Plastics and Reconstructive**	**Urology**	**Vascular**
Adapted 360° Rating Scale – mid-rotation (Formative)		✓		✓					✓
Basic Science Examination (Formative and Summative)				✓		✓			
In-training Evaluation Forms (Summative)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Log Books (Formative)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical long cases with patient (Summative)	✓								
Clinical medium/short cases with patients (Summative)	✓	✓	✓	✓	✓	✓	✓		✓
MCQs (Formative & Summative)			✓	✓					✓
Spot questions (summative)		✓				✓			
On-line interactive case studies (Formative)						✓			
Peer review (Formative)						✓			
Progress Overview Form (Formative and Summative)						✓		✓	
Simulation (Formative and Summative)		✓							
Standardised Patients (Summative)									
Vivas (Summative)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Diagnostic case – no patient (Summative)								✓	
Modules (Formative)								✓	

e Peer Review and Online interactive case studies

The Board of Paediatric Surgery has defined their on-line Critical Appraisal Tasks (CATS) and their Directed Online Group Studies (DOGS) as hurdle requirements. These studies are interactive and are conducted over 4 weeks by Paediatric Surgery. They combine real life de-identified case studies with modules and other written resources in online small group learning led by a supervisor. They incorporate formative feedback from a supervisor and peer review.

f Progress Overview Form

This form is similar in concept to a portfolio. During 2004 Paediatric Surgery developed a Progress Overview Form on which they could maintain a record of their trainees' progress across the range of different requirements.

3.7.2 Unsatisfactory performance of trainees and remedial action

Several actions are being taken to address unsatisfactory trainee performance and remedial action.

- In May 2005, the Court of Examiners will hold a workshop on Assessment and Training. A particular focus will be the assessment of clearly defined competencies in the Fellowship Examination and an improvement in the feedback to failed candidates.
- Orthopaedic Surgery and General Surgery have introduced three-monthly assessment reports to assist in the early identification of any unsatisfactory performance.
- In 2004 the College undertook an internal review of examination feedback to trainees who had failed the Fellowship Examination. Clear guidelines have been produced to improve the quality of feedback. The College has put in place strategies to review the performance of any trainee who fails an examination twice.
- The College is currently undertaking a review of the outcomes of its Fellowship Examination over the last five years. This information will be used to inform curriculum development, suitable remedial action and improvement in this assessment.

A module in the Surgical Teachers Course addresses the processes for identifying and managing unsatisfactory performance. Improvements made to the forms used for in-training evaluation (including the addition of descriptors) have provided supervisors with clarity about expected performance and will improve reliability.

3.7.3 Assessment Outputs and Outcomes

Table 3.5 Data for assessment outputs and outcomes.

Orthopaedic Principles and Basic Sciences Examination (OPBS)

	Candidates presented	Candidates passed	Pass rate (%)
2004	58	53	91

Paediatric Surgery Basic Science Examinations

Segment	Candidates presented	Candidates passed	Pass rate (%)
Anatomy (2004)	6	5	83
Pathology (2004)	1	1	100

Fellowship Examination data

General Surgery

		Total		First attempt		Nonfirst attempt	
		Presented	Passed	Presented	Passed	Presented	Passed
May	Hong Kong	14	6	13	6	1	0
	Auckland	11	7	6	4	5	3
	Sydney	21	11	11	5	10	6
October	Christchurch	49	31	35	27	14	4
		95	55	65	42	30	13
		pass rate:	57.9%	pass rate:	64.6%	pass rate:	43.3%

Orthopaedic Surgery

		Total		First attempt		Nonfirst attempt	
		Presented	Passed	Presented	Passed	Presented	Passed
May	Auckland	8	6	8	6	0	0
	Sydney	42	31	35	27	7	4
October	Christchurch	12	7	1	0	11	7
		62	44	44	33	18	11
		pass rate:	71.0%	pass rate:	75.0%	pass rate:	61.1%

Plastic & Reconstructive Surgery

		Total		First attempt		Nonfirst attempt	
		Presented	Passed	Presented	Passed	Presented	Passed
May	Auckland	6	4	2	2	4	2
	Sydney	14	13	11	10	3	3
October	Christchurch	3	3	1	1	2	2
		23	20	14	13	9	7
		pass rate:	87.0%	pass rate:	92.9%	pass rate:	77.8%

Cardiothoracic Surgery

		Total		First attempt		Nonfirst attempt	
		Presented	Passed	Presented	Passed	Presented	Passed
May	Sydney	4	1	2	1	2	0
October	Christchurch	3	0	1	0	2	0
		7	1	3	1	4	0
		pass rate:	14.3%	pass rate:	33.3%	pass rate:	0.0%

Table 3.5 continued

Otolaryngology

		Total		First attempt		Nonfirst attempt	
		Presented	Passed	Presented	Passed	Presented	Passed
May	Auckland	5	5	5	5	0	0
	Sydney	11	7	10	6	1	1
October	Christchurch	4	3	0	0	4	3
		20	15	15	11	5	4
		pass rate:	75.0%	pass rate:	73.3%	pass rate:	80.0%

Neurosurgery

		Total		First attempt		Nonfirst attempt	
		Presented	Passed	Presented	Passed	Presented	Passed
May	Sydney	4	3	3	2	1	1
October	Christchurch	3	1	2	1	1	0
		7	4	5	3	2	1
		pass rate:	57.1%	pass rate:	60.0%	pass rate:	50.0%

Paediatric Surgery

		Total		First attempt		Nonfirst attempt	
		Presented	Passed	Presented	Passed	Presented	Passed
No exam							

Urology

		Total		First attempt		Nonfirst attempt	
		Presented	Passed	Presented	Passed	Presented	Passed
May	Sydney	14	13	13	12	1	1
October	Christchurch	6	5	5	4	1	1
		20	18	18	16	2	2
		pass rate:	90.0%	pass rate:	88.9%	pass rate:	100.0%

Vascular Surgery

		Total		First attempt		Nonfirst attempt	
		Presented	Passed	Presented	Passed	Presented	Passed
May	Sydney	11	7	9	6	2	1
October	Christchurch	5	0	2	0	3	0
		16	7	11	6	5	1
		pass rate:	43.8%	pass rate:	54.5%	pass rate:	20.0%

All specialties combined

250	164	175	125	75	39
pass rate:	65.6%	pass rate:	71.4%	pass rate:	52.0%

3.8 ACCREDITATION OF HOSPITAL POSTS

General Training Principles
Principles guiding College accreditation of hospital posts:

- *Specification of the clinical experience, infrastructure and educational support required of the accredited hospital/training position*
- *Clear processes to determine whether these requirements are met*

Training organisations accreditation requirements cover:

- *Clinical experience, structured educational programs, infrastructure supports such as library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated time for teaching and training and opportunities for informal teaching and training in the work environment*
- *Publication of the above*

Update on developments during 2004-5

- *Significant developments in the College's relations with the State, Territory or New Zealand health care services.*
- *Details of any significant changes to arrangements for the accreditation of training programs, institutions or training posts such as:*
    - *Changes to accreditation policy or principles.*
    - *Changes to the criteria for accreditation.*
- *Brief report on the developments concerning trainee clinical experience, such as*
- *Details on access to outpatient and ambulatory experience*
- *Mechanisms for monitoring the adequacy, supervision and organisation of*
    - *clinical placements.*
- *Changes to the range of hospitals/institutions accredited for training.*
- *Short report on the College's accreditation activities in the last 12 months.*

As mentioned earlier, considerable effort has and is being put into this area. Generic and Specialty-specific criteria are being revised, taking into account the suggestions of Fellows and the jurisdictions, and the requirements of the ACCC determination. It is intended that the criteria will be laid out in a user-friendly format. An explanatory document, which will accompany the accreditation forms, is also being produced.

Table 3.6 Hospital accreditations undertaken during 2004.

Specialty	New Posts	Reaccredited Posts	Total
Cardiothoracic Surgery	-	1	1
General Surgery	10	21	31
Neurosurgery	1	2	3
Orthopaedic Surgery	5	13	18
Otolaryngology Head and Neck Surgery	3	13	16
Paediatric Surgery	-	2	2
Plastic and Reconstructive Surgery	-	4	4
Urology	2	6	8
Vascular Surgery	-	6	6
Total	20	66	89

The Outer Metropolitan Program conducted in 2004-5 has brought a small increase in the number of private hospitals accredited in Urology in Queensland and Western Australia. It has also highlighted opportunities which may be available in private hospitals for increased access to outpatients and ambulatory experience, particularly in NSW.

General Surgery is piloting a process which they have developed to more accurately monitor the clinical experiences of their trainees during each rotation. A 'Points Scheme', based on trainees' logbook figures, has been developed by some of the Younger Fellows to more clearly identify the kind of case-mix that they might expect in each post. During the first half of 2005 it will be piloted in South Australia and Northern Territory with the intention of trialling it in a larger region in the second half of the year.

Discussion is taking place on the most appropriate method of obtaining feedback from trainees on their training experience. A pilot study is in development to facilitate this process. There are no significant studies in the international literature to inform this process, although certain training schemes in other countries are attempting to overcome this.

3.9 ASSESSMENT OF OVERSEAS-TRAINED DOCTORS

Update on developments during 2004-5

- *College's process for assessing the equivalence of the education, training and experience of overseas-trained specialists to that of Australian-trained specialists.*
- *Changes to the process over the last 12 months or planned in the next 12 months, with brief comment on the reasons for the changes.*
- *Issues relating to the assessment of oversees trained doctors, specifically:*
    - *duration of assessment*
    - *training and educational proposals*
    - *liaison with external organisations*
    - *the College and the AMC*

3.9.1 Assessment policy and procedure

The processes for assessing the suitability of overseas-trained doctors for practise as surgeons in Australia are in accordance with the principles outlined in the:

- AMC "Application procedures and requirements for specialist assessment"
- AMC/Committee of Presidents of Medical Colleges/State and Territory Medical Boards/DoHA/State and Territory Health Departments "Assessment process for Area of Need specialists: user's guide"
- AMC/CPMC (JSCOTS) "Assessment of Overseas Trained Specialists: Template for Colleges".

In addition in March 2004, the Specialist Medical Colleges in conjunction with Australian Medical Workforce Advisory Committee (AMWAC) reviewed several options to streamline the assessment of overseas trained specialists including the following:

- The possibility of automatic recognition of specific overseas qualifications.
- The development of a central data base of qualifications
- Success factors for Area of Need (i.e. employment and career opportunities, family and social opportunities, etc).
- Mapping of Area of Need positions
- Coordination with Overseas Recruitment Agencies

The Specialist Medical Colleges requested that AMWAC investigate the possibility of providing funding for these initiatives.

The College is continuing to explore ways to refine and streamline the paper-based and interview-based assessments. It is also exploring the possibility of automatic recognition of some overseas surgical qualifications, provided the applicants can also demonstrate currency and recency of surgical practice.

Currently assessment of the documentation for an Area of Need surgeon takes eight weeks and other assessments take 10-12 weeks.

The College has begun to develop a formal process for monitoring Overseas-Trained Doctors who are under assessment. This will be refined in 2005. With the rapid expansion of the specialist surgical training curriculum on the College website, overseas-trained doctors will have greater opportunities for self-education. During 2005 the College will notify Specialty Training groups about overseas-trained doctors in their specialties who are required to sit the Fellowship Examination. The Specialty Boards have developed a system of increasing support to ensure that Overseas-Trained Doctors will undertake the same examination preparation programs as trainees.

The Censor-In-Chief and Director, Specialist Surgical Training and Assessment have planned to visit the Royal College of Physicians and Surgeons of Canada to assess whether the Canadian training program is substantially comparable to the Australian and New Zealand program. There has been significant work planning this visit, including research into the Canadian training system and the design of tools to evaluate Canadian programs.

3.9.2 Assessment criteria

The test used by the College to assess the surgical skills, knowledge and experience of an overseas-trained doctor is "substantial comparability to an Australian- or New Zealand-trained surgeon". The elements of such a test of substantial comparability are that the doctors have an acceptable overseas qualification, acceptable competency according to the RACS list of competencies (see Appendix 1) and acceptable recency and currency of surgical practice. The assessment tools include a paper-based assessment of curriculum vitae, testimonials and log books, an interview to ascertain non-clinical competencies, and practice assessment by oversight. The doctor may be required to present for the Fellowship Examination. Importantly, there is no implication of equivalence of training or conforming within Australian and New Zealand surgical specialties, which gives the College scope to accept experienced surgeons whose training programme may have been different.

The College assesses each overseas-trained doctor on an individual basis, scrutinising a range of documentation supplied by the doctor that covers their education, training, qualifications and surgical experience. This documentation is forwarded to an assessment team comprising the College's Dean of Education, the relevant Specialty Board Chair, and the Censor-in-Chief or nominee. Following assessment of the documentation an interview with the applicant is usually scheduled. In rare cases an interview may not be required, such as following review of the documentation showing that the applicant is clearly not substantially comparable to an Australian- or New Zealand-trained surgeon. In such cases the College would issue a written assessment with recommendations.

The interview panel comprises the relevant Specialty Board Chairman, the Censor-in-Chief or nominee and a jurisdictional representative. Interview panel members may also include other Specialty Board Chairs or the Dean of Education.

The semi-structured interview comprises a series of standard questions and brief hypothetical scenarios. The aim of the semi-structured interview is to explore competencies and attributes relating to surgical practice:

- ability in terms of professional performance
- professional ethics
- professional insight
- professional team work and relationships
- professional approach to patients
- professional communication skills (including effective spoken communication in English)
- ,the ability to adapt to the Australian health care system (if appropriate).

Each section of the interview is rated by each interviewer before a consensus score is reached. The jurisdictional representatives are equal and full voting members of the panels. The recommendations arising from the interview are determined by the profile of scores across the different competencies and attributes.

The College grants exemptions wherever the documentation received from an overseas-trained doctor demonstrates substantial comparability. For some applicants this exemption applies to BST and for others it can apply to both BST and AST.

3.9.3 Assessment Outputs

The number of OTD assessments is increasing, with the number of applications doubling in the past 6 months (Table 3.7).

Table 3.7 Number of assessments of Overseas-Trained Doctors.

	Standard	Area of Need
July 2002 - June 2003	41	15
July 2003 - June 2004	46	19
July 2004 - December 2004	43	14

4. FELLOWSHIP - CONTINUING PROFESSIONAL DEVELOPMENT

Provide details of any significant changes to the College's continuing professional development programmes and any changes planned within the next 12 months, together with a brief statement of reasons for the change including:

- *Changes to policy or principles relating to continuing professional development*

Policies relating to the College's Continuing Professional Development (CPD) Programme are current for the period 2004 – 2006.

4.1 REQUIREMENT TO BEGIN PARTICIPATING IN CPD PROGRAMME

In response the New Zealand Medical Council's requirement for surgeons to have evidence of participation in an approved CPD Programme for vocational registration the College in 2004 approved a recommendation that Fellows will have a requirement to begin participating in the CPD Programme immediately following admission to Fellowship. Prior to this, Fellows had a requirement to begin participating in the CPD Programme in January the year after gaining Fellowship. (In some cases this had resulted in Fellows not participating for up to a year after commencing independent practice.)

4.2 CPD DATA COLLECTION

Data collection for the CPD Programme is now available online via the College website. Fellows can now access a CPD Online Diary to record CPD activities in a real time format.

- *Changes to the categories of activity recognised for continuing professional development*

There have been no changes to the categories of activity recognised in the College's 2004 – 2006 CPD Programme. The 2004 – 2006 CPD Programme Information Manual outlining the requirements is available at: http://www.surgeons.org/edu/cpd/CPD_Manual_2004.pdf

- *Changes to the College's process for endorsement of educational activities/meetings*

The Professional Development and Standards Board has recently given in principle support for the approval of small group learning and interactive clinical/ surgical skills at five points per hour, in addition to the current one point per hour option in the CPD Programme. The 2004 – 2006 CPD Programme is based on a points system to allow weighting of components or educational value. Incorporated in this approach is an emphasis on active learning.

- *Initiatives to evaluate professional development programmes.*

The College undertakes regular process evaluation of the CPD Programme including reporting on compliance and participation using a variety of parameters such as practice type, specialty and region/ country.

All professional development workshops and courses are evaluated and results are carefully considered to assist with future planning and to ensure that the needs of Fellows are being met.

- *That the College clarifies its position on issues of self-regulation and recertification*

The recertification process continues to be self regulatory. Fellows report CPD data to the College annually and 2.5% of Fellows are randomly selected to verify their CPD data each year.

- *That the College formulates regulatory measures to address non-participation, within the framework of AMC/CPMC initiatives and NZMC requirements*

Developing a process for addressing incentives and sanctions for the CPD Programme is a key component of the College's 2004 – 2006 Strategic Plan. Measures to promote participation and compliance have been discussed at length by the Professional Development and Standards Board. As a way forward to address the issue, the names of Fellows who comply with the requirements of the 2004 – 2006 CPD Programme will be made available on a publicly available list on the College website, following a formal consent process.

- *The College should consider encouraging major surgical units to offer preceptorships for retraining of Fellows in new developments and techniques. These would involve individual training for a specified time and should provide maximum operating experience to participants.*

The College is actively considering this issue and will be seeking support for such an initiatives from jurisdictional partners and licensing authorities to ensure the success of such a scheme for both the retraining doctor and the community.

- *The further development and specification of the College's educational programmes, including Continuing Professional Development programmes.*

The CPD Programme is reviewed in detail every three years. In addition, the College is continually developing new professional development opportunities for Fellows. Recently developed professional development activities include Winding Down from Surgical Practice, Dealing with Difficult Patients and Work/Life Balance. The College is also currently exploring a postgraduate pathway for the Surgeons and Managers Workshop.

4.3 PARTICIPATION IN THE 2001 – 2003 CPD PROGRAMME

Provide information on the rates of participation by Fellows in the last CPD cycle. If applicable comment briefly on actions taken by the College in response to low participation rates or actions aimed at improving participation in CPD.

Ninety three percent of Fellows have participated in the 2003 CPD Programme and 92% have complied with the annual requirements. Overall results for the 2001 – 2003 CPD Programme indicate that 88% of Fellows have complied for the triennium.

In the past year the College has surveyed non-participants. The survey was developed to collect information about the barriers and problems experienced by Fellows who have not participated in the Programme.

The survey was issued to Fellows who have not participated (not returned a recertification data form) for the 2002 CPD Programme, with a letter from the College President. The survey raised a number of themes including communication, timeliness of data collection, consideration for rural Fellows and recognition of other CPD Programmes as approved pathways for recertification.

In addition, the College launched data collection for the CPD Programme online, to enable Fellows to record CPD data in a real time format. The College believes this service will also encourage Fellows to participate in the CPD Programme. The Section of Breast Surgery requires that those who wish to be full members should submit completed audit data forms for review.

5. ISSUES IDENTIFIED BY THE AMC

For colleges that have been formally reviewed by the AMC, provide a brief report on the college's response, since its last report, to the issues identified for attention in the AMC Accreditation Report.

- *Memorandums of Association with the Specialties*.
- *The further development and specification of the College's educational programs, including continuing professional development programs.*
- *Integration of the non technical aspects of surgical practice such as those set out in the CanMEDS document in training and assessment.*
- *Development of systems for program monitoring and evaluation.*
- *Requirements for selection consistent with the Medical Training and Review Panel Report - the Brennan principles.*
- *Further attention to the issues relating to non accredited training posts.*
- *Improved mechanisms for formative assessment of trainees.*
- *Review of the criteria and processes for accreditation of training posts and institutions.*
- *Review of the strategies and mechanisms for communication to and from the College, trainees, supervisors, mentors and trainers.*
- *Further attention to the issues relating to assessment of overseas trained doctors.*

These issues have not been addressed individually, as they are covered by preceding sections of this report.

Appendix I

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Definition of Surgical Competence

The RACS mission is to provide safe, comprehensive surgical care of the highest standard to the communities we serve. In order to meet this standard, the aim of RACS training and development programs is to certify specialist surgeons with the following attributes:

- Medical Expertise
- Technical Expertise
- Judgement - Clinical Decision Maker
- Communication
- Collaboration
- Management and Leadership
- Health Advocacy
- Scholar and Teacher
- Professionalism

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

- *cognitive* (acquisition and use of knowledge to recognise and solve real-life problems),
- *integrative* (appraisal of investigative data against patient needs in clinical reasoning, manage complexity and uncertainty, application of scientific knowledge in practice),
- *psychomotor* (procedural knowledge, technical skill, manual dexterity, and adaptability),
- *relational* (the ability to communicate effectively, accountability, works with others, consultative, resolving), and
- *affective/moral* (self-awareness, ethical, critically reflective, responsible, healthy, safe).