1 INTRODUCTION

REVIEW OF SPECIALIST MEDICAL EDUCATION AND TRAINING PROGRAMS

The Australian Medical Council (AMC) is the authority in Australia responsible for the accreditation of medical courses leading to primary medical qualifications. This accreditation allows the graduates of Australian and New Zealand medical schools to apply for registration as a medical practitioner in the Australian States and Territories. The Medical Council of New Zealand uses the AMC's accreditation reports to make its own decision about the recognition of the Australian and New Zealand medical schools in New Zealand.

In 1998, the Commonwealth Minister for Health and Aged Care invited the AMC to develop a new model for recognising medical specialties and registering individual medical specialists in Australia. As part of these reforms, the AMC has been working with the specialist medical colleges, the State and Territory medical boards and others on the following proposals:

1. A new, national process for assessing requests to establish - and have formally recognised - medical specialties.

2. A new national process and criteria for accreditation of specialist medical education and training and professional development programs.

3. Enhancement of the system of registration of medical practitioners, including medical specialists.

The aims of the proposed process for accreditation of specialist medical education and training and professional development programs are:

1. To assess whether the education, training and professional development programs of the Specialist Medical College being reviewed:
- *are relevant to the objectives and outcomes determined by the College,*
- *are appropriate in terms of modern educational methods and clinical practice,*
- *include appropriate assessment methods that test the trainee's knowledge, clinical skills, attitudes and expertise for safe and competent practice of the specialty.*

2. To encourage further improvements and developments in the program being accredited and so enhance its educational quality.

3. *To provide an opportunity for the organisation being accredited to review and self assess its program. The collegiate nature of accreditation should facilitate discussion and interaction with colleagues from other disciplines to benefit from their experience.*

4. *To assure the community that a doctor who has successfully completed an accredited specialist education and training program is able to practise as a specialist in that area and is being assisted to maintain and enhance her/his knowledge, competence and performance.*

5. *To provide the basis for medical boards and the Health Insurance Commission to grant the legal requirements for practice in the relevant specialty.*

6. *To be focussed on the achievement of objectives, maintenance of academic standards, public safety expectations, and good outputs and outcomes rather than on detailed specification of curriculum content relevant to the specialty or discipline*[1].

A broadly based Consultative Committee on Specialist Accreditation and a smaller Working Group on Specialist Accreditation have developed the accreditation model and draft *Guidelines for the Accreditation of Medical Specialist Education and Training and Professional Development Programs,* which describe the proposed evaluation process and standards. A summary of the draft Guidelines is at Appendix 1.

Since this is a new development, the AMC decided to test the proposed model before deciding on its implementation. With funding by the Commonwealth Department of Health and Aged Care and the assistance of the specialist medical colleges, two colleges are being reviewed using the process described in the Draft Guidelines for Accreditation. Following the reviews, the AMC will host a workshop to develop recommendations on the implementation of the accreditation process for consideration by the AMC Council.

Three Colleges volunteered to participate in the pilot: the Royal Australasian College of Surgeons, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Royal Australian and New Zealand College of Radiologists. The AMC chose to proceed with the Royal Australasian College of Surgeons and the Royal Australian and New Zealand College of Radiologists.

THE REVIEW PROCESS

The AMC's draft Guidelines for Accreditation propose the following broad goals of specialist education and training:

[1] Australian Medical Council *Guidelines for the Accreditation of Medical Specialist Education and Training and Professional Development Programs.* 2000 Pages 2 -3

1. *Specialist education and training is to enable the trainee to gain an understanding of the scientific basis of the discipline and to learn through exposure to a broad range of clinical experience in the relevant specialty.*

2. *On completion of training, a practitioner is able to undertake unsupervised comprehensive medical practice in the relevant specialty (including general practice).*

3. *The training should include a process of assessment that tests whether the trainee has acquired the requisite knowledge, skills and attitudes to practise in the specialty at an appropriate standard.*

4. *Trained specialists (including general practitioners) must be prepared to assess and maintain their own competency and performance through continuing professional education, maintenance of skills and the development of new skills.* [2]

In a review, a team appointed by the AMC considers the specialist medical college's processes of specialist medical education and training and its processes of professional development. The draft Guidelines for Accreditation identify key features of successful programs, and the review considers the College's processes against the goals and objectives set by the College and the recommendations in the draft Guidelines.

The review is conducted as follows:

- The College prepares an accreditation submission, guided by the draft Guidelines for Accreditation.
- The AMC appoints an accreditation team, after seeking the College's views on the expertise required.
- The team considers the College's draft submission, identifies the major issues to be addressed and decides on the meetings, site visits and other information that will assist it to complete a comprehensive review.
- The Team Convenor and College office bearers discuss the team's feedback and plan the review.
- The AMC seeks submissions on the education and training and professional development programs of the College from stakeholder groups.
- The team completes its review and prepares a detailed report on the College's training and professional development programs.

[2] Australian Medical Council. *Guidelines for the Accreditation of Medical Specialist Education and Training and Professional Development Programs.* 2000 Page 3

REVIEW OF THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

The review involving the Royal Australasian College of Surgeons began when the test involving the Royal Australian and New Zealand College of Radiologists was already well advanced, and the review process was modified based on the experience of the first review.

The review began with a meeting between the AMC and College office bearers and staff to discuss the information the College should provide in its accreditation submission. The AMC appointed individuals to the Surgeons Accreditation Team (called 'the Team' in this report) and chose a Team Convenor after discussion with the College on the expertise required. The Team is comprised of a mix of local and international medical and non-medical members, including members experienced in AMC process of accreditation of medical schools, educationalists, a trainee of another College's training program, links to the Working Group and State medical boards, and a Fellow of the Royal Australasian College of Surgeons. The members of the Team are listed in Attachment 2.

The Royal Australasian College of Surgeons submitted a first draft of its accreditation submission in December 2000. The AMC reviewed this draft and provided written feedback to the College.

On 7 February 2001, the Team Convenor and Secretary met the College's Censor-in-Chief and College staff to discuss the draft submission and the plans for the accreditation.

The College lodged its revised submission in late March, and this was considered by a meeting of the Team on 2 April 2001. This meeting also generated a schedule of meetings and site visits necessary to the review, and additional questions concerning the College's training and professional development programs. In addition to the College's submission, the Team sought comments and feedback on the College's programs through surveys of the College's trainees and supervisors of training, and letters to the State health departments, the other specialist medical colleges and the Deans of medical schools.

In May 2001, Team members visited selected sites of surgical training in Australia. The purpose of these visits was to allow the Team:

- To form a judgment about the robustness of the College's own process of accreditation of training sites, and
- To consider whether the College's educational goals were achievable in the training environment.

The visits also allowed Team members to supplement the information from the College's accreditation submission as well as the stakeholder surveys.

The Team chose 17 training sites to visit in consultation with the College and taking into account:

- the desirability of visiting a mix of large and small sites and urban and rural sites in a number of States;
- the number of trainees and supervisors of training at each site;
- the best use of the time of the Team and of resources.

To illustrate the Team's activities, the programs for the site visits in two cites are included at Appendix 3.

APPRECIATION

In agreeing to participate in the trial of the accreditation process, the College has played a significant role in helping to refine the process. The Team was greatly assisted by the support and commitment of the office bearers of the Royal Australasian College of Surgeons: the Immediate Past President, Mr Bruce Barraclough, the President, Mr Kingsley Faulkner, the former Censor-in-Chief and now Vice President, Mrs Anne Kolbe, and the Censor-in-Chief, Professor Richard West AM.

The Team is also grateful to the College staff, led by the Chief Executive, Dr Vin Massaro, who prepared the accreditation submission and coordinated the College's participation in the trial.

The Team also wishes to acknowledge the support of College staff in the States offices, who coordinated the Team's visits to training sites, and the assistance of the hospitals that hosted visits from Team members. The Team is grateful to all those who contributed to the review by attending meetings and/or by responding to the Team's surveys.

THIS REPORT

This report contains the Team's findings on the training and professional development programs of the Royal Australasian College of Surgeons. It identifies what the Team perceives to be the strengths and weaknesses of the College's processes, and makes recommendations on areas requiring attention.

The Team has prepared a second report, a commentary on the accreditation process, which is available as a separate document.

Notes on terminology

The AMC draft Guidelines for Accreditation contain definitions for a range of commonly used educational terms. The team has adopted these terms, which are listed in Appendix 4.

2 THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

DESCRIPTION

The Royal Australasian College of Surgeons (RACS) was formed in 1927 and is registered under the State of Victoria Companies Act 1928. It functions as an independent body whose chief concern is the training and assessment of surgeons.

The College Mission is: 'We aim to provide safe comprehensive surgical care of the highest standard to the communities we serve.' The stated objectives of the College are:

- training and examination of doctors seeking to become surgeons through Fellowship of the College;
- continuing education and maintenance of standards of surgical practice;
- fostering surgical research;
- involvement in the community in promulgating and achieving high standards of health;
- developing good international relationships with a view to fostering high surgical standards.

The Royal Australasian College of Surgeons has 5176 Fellows of whom 4053 reside in Australia and 661 are in New Zealand. About 90 per cent of surgeons practising in Australia and New Zealand are Fellows of the College.

There are 1510 trainees registered with the RACS: 771 in the basic surgical training program and 739 who have proceeded to advanced surgical training in one of nine specialty streams. There are 22 'endorsed' trainees, who have already completed a Fellowship but are training for another specialty. The College Council makes the award of Fellowship of the Royal Australasian College of Surgeons (FRACS) on the recommendation of the Censor-in-Chief. The fellowship requirement is usually satisfied by successful completion of written and clinical examinations taken after a period of satisfactory supervised training.

The College headquarters are in Melbourne. There are regional offices of the College in each Australian State and in Wellington, New Zealand. These offices are chiefly concerned with local administrative matters and serve a local committee with a Chairman and office bearers; their involvement in the training process is incidental.

STRUCTURE

The RACS has recently revised its structure, and in the process has sought to separate governance and management. The governance role is seen to be the province of the Fellowship through an elected Council. Each of the geographic regions and surgical specialties is represented on Council; if not by popular election, then by cooption. The Council Executive is elected annually by the (elected) members of Council and comprises the President, Vice President, Honorary Treasurer, Censor-in-Chief, and Chairmen of the Court of Examiners, the Board of Basic Surgical Training, and the Board of Continuing Professional Development. The College Chief Executive, who also holds a position on the Executive, oversees the management of the College. In addition, the Chief Executive is responsible for advising the Council and providing the management infrastructure to ensure that policy decisions can be implemented without the direct involvement of Fellows.

The Division of Academic Services supports the committees responsible for the College's education and training programs. Of the College's 109 staff members, 27 are employed through this Division. The Board of Basic Surgical Training oversees the educational support of basic surgical trainees and the Censor-in-Chief's Committee the support of advanced surgical trainees. In the revised College structure the latter is replaced by a Board of Advanced Surgical Training, which will come under the direction of a new over-arching education policy forum, the Education Committee. The College has also appointed a part-time Dean of Education to provide leadership of its academic activities. These changes were still being implemented at the time of the AMC review.

The Board of Basic Surgical Training comprises representatives of the basic science Discipline Subcommittees (anatomy, pathology and physiology), the three skills courses undertaken by basic trainees, the OSCE Subcommittee, and representation from the Regional Supervisors of Basic Surgical Training. The Censor-in-Chief's Committee comprises the Chairmen of the Court of Examiners and of the Board of Basic Surgical Training, a representative of the Rural Surgery Training Program and representatives of the nine specialty surgical streams. These representatives of the nine surgical streams in turn Chair their particular Specialty Board. Each Specialty Board is comprised of the Chairs of the Regional Boards.

Members of these committees are not paid for their work.

The Department of Continuing Professional Development (CPD) is responsible for ensuring that Fellows understand and comply with the requirements for recertification. Development of College policy and administration of the CPD program is the responsibility of the Board of Continuing Professional Development.

STRATEGIC ISSUES OF CURRENT IMPORTANCE TO THE COLLEGE

The Team identified a number of strategic issues of concern to the College.

Strategic planning The College is in the midst of profound changes in its approach to the design and delivery of postgraduate medical education. The most significant of these is the decision to move from being an assessment body to one that also delivers educational material to its trainees. The Team commends the College for its enterprise in endeavouring to adapt to new challenges in education. The College has also developed a Strategic Plan 2000 – 2005, which includes a mission statement, goals, key objectives and key performance indicators. Clearly it is important for the College to tie its educational program performance to its strategic plan.

ACCC authorisation process The RACS is devoting considerable resources to its application for authorisation by the Australian Competition and Consumer Commission. The College had sought authorisation under sub-section 88 (1) of the *Trade Practices Act 1974* to permit it to conduct its surgical training program and to assess overseas-trained surgeons, functions that the ACCC considers may be in breach of the *Trade Practices Act.* As the documents prepared by the College to support its authorisation application contained details of issues relevant to the AMC process the Team was grateful for the opportunity to review them.

Dissonance between service and training Concerns about the difficulties of separating service commitment from training were frequently raised by supervisors and trainees during the accreditation review process. As health sectors and hospitals in the eight Australian States and Territories and in New Zealand employ surgical trainees, the College must respond to pressures in nine distinct jurisdictions.

AMA safe hours project The Australian Medical Association has recently been engaged in the development of a policy on maximum safe hours for junior medical staff. This has been identified in a number of forums as potentially a major challenge to surgical training. Many of those interviewed by the Team predicted a reduction in working hours would increase substantially the time required for trainees to complete training programs.

Communication issues As the College moves through a period of profound change, it needs to implement strategies to solicit input from Fellows and trainees and keep them informed of continuing developments. Although the College is clearly attempting to enhance communication with its Fellows

and trainees, in other parts of this report the Team has raised issues regarding the College's communication with stakeholders, including trainees, overseas-trained surgeons, hospitals administrators and health departments. The Team urges the College to review its strategies for communicating with stakeholders, with a view to increasing the flow of information in both directions.

The Team regards the major commitment of the College, through its unpaid Fellowship, to an educational process of high quality as its greatest asset.

3 SPECIALIST MEDICAL EDUCATION AND TRAINING PROGRAMS

OVERVIEW

The Royal Australian College of Surgeons has ten training programs, all of which are offered in Australia and New Zealand. Some are also available in Singapore and Hong Kong.

- The Basic Surgical Training (BST) Program is a period of between two and four years training undertaken by all trainees in surgery.
- The nine Advanced Surgical Training (AST) Programs include:
  - General Surgery, which is a five-year program with the first three years covering a broad spectrum of surgical procedures, and the remaining two years focussing on one of the subspecialty areas. General Surgery includes a subspecialty of Rural Surgery.
  - Cardiothoracic Surgery, which is of six years duration including two years of General Surgery and four years Advanced Training in Cardiothoracic Surgery.
  - Neurosurgery training is of five years duration and may include an optional year of research or overseas experience.
  - Orthopaedic Surgery is a four-year program. One year may be spent in an approved post of medicine, surgery or in research.
  - Otolaryngology - Head and Neck Surgery, which is a four-year period of training.
  - Paediatric Surgery is a six-year program, with three years in general surgery and three years in the Paediatric Surgical Training Program.
  - Plastic and Reconstructive Surgery is of five years duration including one year in surgery in general and a further four years in Plastic and Reconstructive Surgical Training.
  - Urological Surgery is a five-year program including one year in general surgery and a further four years in Urological Surgical Training. The final year is in an approved post interstate or overseas.
  - Vascular Surgery, which is five years, involving two years in the training program in General Surgery and three years in approved posts for Vascular Surgery Training.

The College is in frequent communication with the international surgical community, allowing regular review of the practices and standards of comparable Colleges throughout the world. The College has

been called upon, on numerous occasions, to advise on systems, procedures and models that the College has developed for surgical training.

BASIC SURGICAL TRAINING (BST)

The BST Program has recently undergone a major restructure from a self-selected, self-taught system with a high attrition rate to a structured program occupying between two and four years. In the BST Program trainees are expected to acquire a sound knowledge of the theory and practice of surgery in areas common to all branches of surgery and a satisfactory understanding of basic surgical science.

The program entails twelve months in approved surgical posts and twelve months in surgical, medical or basic science posts or approved research. This period must include at least twelve weeks in an emergency department and eight weeks in an intensive care/high dependency area.

Trainees are also expected to complete the Surgical Training Education Modules (STEM), which is a distance learning program based on the application of basic sciences to clinical practice. In addition, there are three courses designed to provide trainees with 'hands on' practice of surgical skills.

- A three-day Basic Surgical Skills course (BSS) is undertaken during the first six months of basic surgical training. It is designed to give the trainee the opportunity to practise under close supervision skills such as suturing. The course objectives are clearly specified. Courses are conducted in each State.
- The Early Management of Severe Trauma course (EMST) is undertaken during the second half of the first year of training. This course, which is based on the Advanced Trauma Life Support course of the American College of Surgeons, is an intensive course in the management of trauma victims in the first one to two hours following injury. It occupies two and a half days of structured teaching with opportunities for development and practice of necessary skills.
- The Care of the Critically Ill Surgical Patient course (CCrISP) is undertaken in the first half of the second year of basic training. This new course is designed to advance the practical, theoretical and personal skills necessary for the care of critically ill surgical patients. It involves three days of instruction and experience, partly using simulators to demonstrate priorities for treatment of surgical patients.

Although some concerns were raised about cost, most trainees were positive about the changes in the BST. The vast majority of surgeons also voiced their support of the new program's features. The

formalisation of the program was perceived as critically needed. The two skills courses completed thus far by the trainees (BSS and EMST) were extremely well received.

The Board of BST, chaired by Professor Stephen Deane, has set important goals for program improvement as indicated in the document 'Vision for the Next Two Years' dated May 2001. There have been many changes in the program, and the Board may want to plan carefully the timing of any additional changes as too much at this point could be confusing, frustrating to stakeholders, and disruptive. Nonetheless attention to several areas is needed and, with a well thought out dissemination plan, positive changes can only add to the quality of the current BST Program.

The Team noted that the Board of Basic Surgical Training has established objectives for the Basic Surgical Training, which are:

- the development of a sense of responsibility to patients staff and the community;
- the understanding of basic sciences relevant to the practice of surgery as in the current syllabus or as redefined from time to time;
- the application of these basic sciences to clinical surgery;
- the acquisition of appropriate basic surgical skills;
- the development of appropriate interpersonal and communication skills;
- competency in clinical assessment and the use of diagnostic modalities;
- sufficient maturity to enter Advanced Surgical Training;
- understanding and commitment to continuity of patient care.

It seems that these principles are not widely known by supervisors or trainees.

It would be helpful if the Board could adopt a standardised format for documenting learning objectives. A list of topics similar to those listed in a textbook does not qualify as learning objectives. Educational objectives should be stated in terms of what students will be able to do as a result of various educational experiences provided or gleaned. In order for these objectives to be meaningful and to achieve the desired effect on the program they must be adopted by the trainers and integrated into the training program. There is a need for correlated planned instructional activities as well as spontaneous clinical teaching, all directed to address the learning objectives. There should not be so many objectives as to be trivial or overly voluminous and they should be directly tied to the performance evaluation system. In accrediting hospitals for training the College should require that each hospital demonstrate its effectiveness in helping trainees accomplish the objectives, or at least its

provision of both formal and clinical learning opportunities that are in accord with these objectives. It would also be helpful to have a document that clearly defines clinical expectations, preferably aligned with the learning objectives.

The STEM modules are designed to supplement trainees' learning activities. Some learners found them quite useful. Several trainees expressed discontent with their current format and were confused about their processing and 'marking' at the College level. The modules might be more useful if learners received feedback on their performance. Periodic small group sessions to review modules with trainees who had completed them would add educational benefit and value. To demonstrate the importance of the topics addressed, the Board of BST should consider including questions in the examination that sample STEM material. The STEMs already available should be evaluated both from the perspective of process (access, cost, etc.) and outcome (trainee learning perception, exam questions).

Inevitably with a new development, some problems have occurred in the implementation of the STEM modules, particularly with respect to the Web-based modules. Trainees need to be informed of progress as these problems are solved. The Team noted that some interactive dialogue between trainees on the online STEM modules had occurred and considered this an excellent initiative.

The Board of Basic Surgical Training may wish to consider establishing a set of *regional* BST conferences that specifically address trainees' learning needs. Topics and skills taught should be consistent with the learning objectives discussed above.

Performance feedback is an area requiring attention. Trainees reported consistently to the Team on the lack of feedback from the College about matters related to their training. The logbook is one such area. Trainers should be provided with instruction on giving constructive feedback and supervisors need assistance in setting up feedback systems (when should it be given, by whom, how often, follow up).

There is currently no mechanism for communication between a trainee's supervisors at successive posts, and this does not serve trainees' educational needs well. A system that tracks every trainee's progress both at their assigned posts and overall across years of training needs to be put in place. This should be a computerised database. Supervisors at differing posts should be able to view a trainee's file to identify any previous performance weaknesses so these can be addressed and observed.

There are many pieces of information being sent to trainees without efficient coordination through the RACS. Although it is important not to create an information bottleneck, the College should publish

one book or information source, such as a Web page, that details all the information relevant to the BST for supervisors, trainees, applicants and trainers. Information management could also be improved in other areas, such as the trainee logbook. An easily managed computerised system should be set in place to ensure summary data can be accessed in a timely and consistent manner by the RACS and supervisors needing to monitor operative case logs. Enhancements such as these will greatly improve understanding among those involved in the educational process.

Recommendations

That the Board of Basic Surgical Training develops and publishes the learning objectives of the Basic Surgical Training Program.

That the Board of Basic Surgical Training devise:

- *A mechanism for providing information to trainees about their performance in the STEM modules and*
- *Mechanisms for evaluation of the modules, in terms both of process and outcome.*

These recommendations on performance feedback apply to Advanced Surgical Training also.

That RACS develop a system for tracking the progress of trainees both at their assigned posts and across years of training.

That RACS review its system of providing information about the BST to supervisors, trainees, applicants, and trainers, with a view to increased efficiency and clarity.

ADVANCED SURGICAL TRAINING (AST)

The Team recognises that in a review such as this it is not possible or intended to comment in detail on the content or specific education and training programs of each AST Program. What follows are the Team's observations concerning important elements of Advanced Surgical Training; these comments are amplified in later sections in the report. General comments are followed by observations by Team members on the individual AST Programs, which attempt to give an overview of common issues raised regarding training and educational processes.

Structure

Advanced Surgical Training is overseen by the Censor-in-Chief, who chairs the Board of Advanced Surgical Training. There are nine Specialty Boards of the RACS, which are represented on this Board.

There are nine AST Programs. The nine Specialty Boards have varying governance roles over their specialties. As indicated below, for some specialties independent craft group associations play a major role in the oversight of the training program:

1.	Cardiothoracic Surgery	Specialty Board of RACS
2.	General Surgery	Specialty Board of RACS
3.	Neurosurgery	Specialty Board of RACS Neurosurgical Society of Australasia
4.	Orthopaedic Surgery	Australian Orthopaedic Association
5.	Otolaryngology - head and neck surgery	Australian Society of Otolaryngology, Head and Neck Surgery
6.	Paediatric Surgery	Specialty Board of RACS
7.	Plastic and Reconstructive Surgery	Specialty Board of RACS
8.	Urology	Urological Society of Australasia
9.	Vascular Surgery	Specialty Board of RACS.

The Boards overseeing AST Programs have Regional Training Subcommittees, though for the numerically smaller specialties these subcommittees play a lesser role. The Regional Training Subcommittees comprise local supervisors of Advanced Surgical Training.

Finally, it is important to recognise the role of hospitals in the Advanced Surgical Training Programs. The College and relevant Specialty Training Boards oversee the syllabus, review training progress (in particular using logbooks) and administer examinations. The hospitals employ the trainees and derive service in return, as well as providing the training and learning environment. The mix of service

workload and formal training/learning time is a critical component of the trainee's experience, as is the quality and quantity of supervision and teaching the trainee receives from College Fellows on the job.

The structure of the Advanced Surgical Training program is broadly outlined in the *Guide to Surgical Training 1996*. While this is a concise and useful booklet, it is somewhat dated and would benefit from revision.

Mixed oversight of the AST Programs by the College and Societies/Associations raises significant questions of responsibility, consistency and accountability. The Team was impressed by innovative ideas and practices developed by several of the special societies. There is however a clear need for congruence of purpose. Where the College 'out sources' to an independent body its responsibility for trainee selection, training program design and examination the relationship with this body concerning mutual obligations for advanced surgical training should be made explicit.

Recommendation

That the RACS develops a standard 'Heads of Agreement' that outlines the relationship, responsibilities and accountabilities for AST Programs that involve specialty societies and/or associations.

Syllabus and Advanced Surgical Training content

The AMC draft Guidelines for Accreditation advocate that medical specialists should have the skills to undertake several broad roles in the health care sector, with an understanding of the importance of maintaining and enhancing knowledge, competence and performance of these roles. These roles are medical expert, communicator, collaborator, manager, health advocate, scholar, and professional[3]. The Team believes that all of these roles are important in specialist practice.

The syllabus for each AST is outlined in the *Guide to Surgical Training 1996*. Emphasis is very much on the medical expert role, and learning by experience under a traditional apprenticeship model. Some Specialties were able to provide considerably more detail on their training syllabus than is available in the *1996 Guide*. There appears to be significant variability in the extent to which each AST has formulated its training syllabus, and the frequency with which this is reviewed and updated.

[3] *The AMC's recommendations draw on the work of the Royal College of Physicians and Surgeons of Canada in the CanMEDS 2000 Project which, through a process of literature review, consumer surveys and focus groups, identified the tasks or behaviours required of medical specialists, organised them into distinct roles, then determined the key competencies for each. See Annals RCPSC Vol 29 No 4 1996 'Skills for the New Millennium' pp 207-216*

The College is moving to embrace roles other than that of medical expert through such innovations as structured interviews for trainees covering areas such as communication with patients, cooperation with staff, stress response, and acceptance of criticism. The College also has a broad commitment to scholarly pursuits through the research elements of AST Programs. In general, however, the syllabus and training requirements in areas such as communication, collaboration, management and health advocacy are not well described. The only training offered in these areas is experience 'on the job' and role modelling by supervisors and mentors. As a consequence, neither trainees nor supervisors appear to be clear on what is expected of them in these areas.

Supervisors and trainees in general felt that AST concentrated on medical expertise and surgical technique but was much less developed in other areas. The written material provided by the College tends to reinforce this observation.

There are opportunities to:

- Review training syllabi for all AST Programs and present them in a standardised format, and
- Strengthen the content and syllabus requirements relating to communication, collaboration, management, health advocacy and professionalism.

Recommendation

That RACS review the syllabi of all AST Programs and broaden them to encompass formally roles as communicator, collaborator, manager and health advocate.

Transition from Basic Surgical Training

The process of advancing from successful completion of Basic Surgical Training to Advanced Surgical Training in the chosen specialty appears simple, but it is not. Each AST Program has a broadly similar trainee selection process, but with subtle distinctions. In general, the smaller programs are more national in their selection and training processes, whereas the larger programs such as General Surgery and Orthopaedic Surgery rely more on Regional Training Boards and local hospital supervisors.

The College has made considerable efforts to standardise trainee selection and to ensure selection is based on merit. Interviews with trainees and Fellows who have been involved in the process suggest

that these efforts have improved the selection process. However, there has been little formal evaluation of selection and this would be a useful exercise for the College to consider. These issues are discussed in greater detail in the section on selection (see pages 34 to 37).

The status of the 'non-accredited' post as a prerequisite to gaining entry to AST is unclear. If it is required, it is difficult to see why it is not regarded as part of the training scheme. Trainees perceive non-accredited positions as a sort of limbo, where they are being tested to assess whether they have 'the right stuff'. The College is moving to eliminate uncertainty regarding the status and role of non-accredited positions/training, and this is to be encouraged. These issues are discussed in greater detail in the section on trainees with intermediate status (see pages 38 to 41).

The relationship of the number of training positions to overall workforce requirements is becoming increasingly important for two principal reasons. First, trainees are being asked to invest an increasing amount of their time and resources into training, and they expect a job at the end. Second, surgeons generate significant health benefit and commensurate health expenditure, so their workforce numbers and productivity are important from a health policy perspective. RACS has worked closely with the Australian Medical Workforce Advisory Committee (AMWAC), and State and Federal Governments over the last decade to link trainee numbers more closely to projected workforce needs. This cooperation is commendable and should continue to be a focus in the future.

The training environment

Advanced surgical training is essentially an apprenticeship. Trainees work in designated training positions under the supervision of Fellows, and acquire exposure to and experience in a range of diagnostic and treatment procedures as outlined in the syllabus. This experience is documented through supervisor reports and the trainee's logbook.

Training is hospital based. The Specialty Boards set the requirements for the training environment through negotiation with hospitals. They periodically monitor and evaluate the training environment through an accreditation process.

Accordingly, the accreditation process is critically important in:

- evaluating the views and performance of trainee supervisors;
- gaining feedback from trainees concerning the strengths and weaknesses of the training posts and general environment;

- engaging the hospital management in discussion regarding the training environment, providing feedback and identifying opportunities for improvement.

Discussions with trainees about accreditation indicated that their participation in the process was variable. Trainees also indicated that they rarely received feedback regarding the outcome of accreditation visits.

Supervisors and hospital managers generally found the accreditation process useful and constructive, though it was dependent upon the people involved as accreditors. Hospital managers observed that there was considerable variation between specialty groups in the approach to accreditation and the extent to which hospital management was involved.

Many trainees mentioned the balance between service requirements and dedicated training/learning time, where the latter is eroded by the former. The problem is said to be increasing.

The training experience and assessment

Feedback and assessment procedures are outlined for each AST Program in the *Guide to Surgical Training 1996*. Discussions with supervisors and trainees indicate that feedback on progress is generally not done well. Trainees feel the onus is on them to seek feedback and this can be stressful. The periodic assessment forms are often completed in a perfunctory manner and not accompanied by verbal feedback. On the other hand, many supervisors (but probably a minority) provide excellent feedback, setting clear performance goals and allocating time for one on one discussion with trainees. Some of these 'benchmark' supervisors have had the benefit of a College training program to hone their skills as supervisors.

For their part, supervisors say they receive limited support and feedback from the College on how they are performing, what trainees think, and where/how they may improve. They are also under increasing time pressure as expectations from trainees and the College increase, and resources within their day-to-day work environment diminish.

As discussed earlier, trainees generally felt that exposure to and teaching of clinical and technical skills was very good. Nevertheless, they noted pressures, particularly in public hospitals, due to increasing emergency loads and the erosion of public outpatient clinics. Some trainees, but not all, were able to overcome these problems by arranging complementary teaching in private hospitals.

Trainees indicated that formal and informal teaching/learning in non-technical aspects of AST including teamwork, communication, leadership and management, and the broader health environment was generally lacking.

Trainees also expressed concern that some training posts and some hospitals had relatively poor resources for trainees, in particular availability of libraries, computers and internet access, and dedicated teaching/study areas.

There are opportunities for improving the training experience and assessment through:

- improved feedback skills development and general support from the College for supervisors;
- more attention by supervisors to the need for formal, structured feedback;
- increased use of mentors;
- structured curriculum and learning tools to cover the non-clinical, non-technical aspects of advanced training.

Advanced Surgical Training in Cardiothoracic Surgery

The Specialty Board of Cardiothoracic Surgery oversees Advanced Surgical Training in Cardiothoracic Surgery. The core elements of the program, including methods of selection and the different ways of entering and completing the program, are outlined in the *Guide to Surgical Training 1996*. The Guide also presents in very broad terms the syllabus for advanced training and the criteria for minimal experience.

The Cardiothoracic Surgery advanced training program includes New Zealand and Singapore. There currently are about 30 accredited training positions, of which 80 per cent are filled with accredited trainees. The program operates on a national/international basis, where the national Board makes decisions regarding selection and allocation to training positions within the program. Cardiothoracic trainees interviewed recognised and accepted that they may be allocated to a post in a different city, state or even country. Such imposed rotations are a feature of a number of the AST Programs. Supervisors generally felt that rotation to different hospitals and even different cities/States was of benefit to trainees, enabling them to experience a variety of practice environments.

The philosophy of the Cardiothoracic Board is that all advanced trainees will successfully complete their training and obtain specialty recognition. There is a formal six-monthly review of all trainees

and reports go from supervisors to State Training Committees. Trainees are required to attend two national meetings per year, where they participate in formal training sessions, meet the Board, and have the opportunity to discuss issues or concerns with members and senior Fellows.

The Board has an active accreditation process, which reviews training positions every five years (or more frequently if necessary). The process involves explicit and separate feedback from trainees.

The main issue facing the Cardiothoracic Board is the challenge of matching early post-fellowship trainees to jobs. Many new Fellows go overseas for further training and may need to wait for an opportunity to return to Australasia. This may present an opportunity for better coordination between workforce planning and recruitment to the advanced training program.

Advanced Surgical Training in General Surgery

The College has developed and begun to implement a new Advanced Training Program in General Surgery. A document outlining the program and the structure, plus the membership and organisation of the Board overseeing the program, was approved by the Censor-in-Chief's Committee in May 2001, and will be considered by the next Council meeting of the College.

The new program, whilst retaining much of the previous program, comprises a range of educational improvements. The distinctive features of the new program are as follows:

- The foundation for the Advanced Training Program in General Surgery is a structured Basic Surgical Training Program assessed by written and oral examinations.
- The expectation is that trainees would move directly from successful completion of the Basic Surgical Training Program to the Advanced Training Program in General Surgery.
- The Advanced Training Program in General Surgery is divided into a three-year segment of advanced general surgical training followed by a two-year (or three-year) segment in general surgery or rural surgery, or in a subspecialty area of clinical practice: colorectal, upper GI hepatobiliary pancreatic surgery, endocrine, breast, trauma, or transplantation.
- Training is provided through experience in operative procedures. Increasingly primary surgical responsibility is expected as trainees progress through the training program.
- A period of research experience is encouraged and this may replace a year of clinical experience.

It was clear from interviews with trainees and training supervisors that the Advanced Training Program in General Surgery is more closely integrated with the College than are most other specialty areas. Reports indicate that the program is implemented in ways that are consistent with the program outline, with a good balance of experience in the surgical skills that characterise the specialty. Indeed, the track record of the Advanced Training Program in General Surgery shows reasonable consistency from region to region, with trainees clear about what they might expect from the program. Trainees consider that the selection process is fair and conducted in a manner that does not place undue stress on the candidate. Indeed the systematic improvements being made to the Advanced Surgical Training Program in General Surgery provide useful guidance for the development of other programs.

The new program comprises a syllabus of surgical topics and a clear structure of progress to be achieved. Broad training requirements are written in an unambiguous manner and guidelines are provided in a number of key areas of training. This outline, however, does not constitute a curriculum. For example, learning objectives and the educational means by which those objectives are reached and assessed are not articulated. In addition there are no specific directions for meeting training requirements or for processes to be followed if the event of failure to meet the requirements.

General surgical trainees and training supervisors suggested a number of ways in which the program might be enhanced educationally. Many of their suggestions are pertinent to other AST Programs, and these are listed at the end of this section. One recommendation for change specific to the General Surgical Training Program is that the practicalities of the rural rotation experience should be examined, particularly in regard to the inevitable dislocation of home and family life.

Rural Surgical Training Program

The RSTP was set up as a subspecialty of General Surgery in 1996. It aims to 'provide high quality, cost effective surgical services to rural Australia'.

Trainees are selected into the RSTP during General Surgical Training. An individual vocational program is designed for each trainee to meet the needs of both the trainee and the intended final place of practice. An example was given of a trainee who planned to work in the Kimberley region of Western Australia, whose general surgical training was being supplemented in obstetrics and orthopaedic surgery.

Trainees, and for that matter rural surgeons, are urged to attend the annual conference of the Provincial Surgeons of Australia. Trainees consider this a mandatory component of their training.

The College has developed an excellent mentoring and support system for Rural Surgical Trainees. Support begins from entry to advanced training. Each trainee is allocated a mentor who is responsible for helping to develop the training program and who becomes a guide and counsellor during the program and into the first years of independent practice. The special society, Provincial Surgeons of Australia, enables trainees to develop professional and social links with established rural practitioners. Professional development activities are arranged in association with the annual PSA meeting.

The Team encourages the College to undertake formal evaluation of the RSTP.

There are currently 42 rural trainees; the aim is to have 50 trainees in positions by 2002, which reflects the AMWAC target. Reflecting the success of this program, the College has identified rural posts for Orthopaedic Surgery. Seven posts are funded and have been occupied from 2001.

Advanced Surgical Training in Neurosurgery

Until recently, the Neurosurgical Society of Australasia provided support to the Neurosurgery Board for handling advanced trainees; this role has now been assumed by the RACS Secretariat.

Neurosurgical trainees are considered for acceptance into the program after completion of basic surgical training. They are expected to have 'some experience in general surgery and in the management of trauma, and if possible, of some of the other relevant specialties'. The Board should consider defining more precisely the requirements for entry into the program, particularly in respect of 'other' required training.

The required period of advanced surgical training is five years, with a maximum of two years in any one training unit. This may include a year of optional activity such as research or overseas experience. The Board sets guidelines for progressive responsibility in various types of surgical procedure during four years of the training period as well as a detailed syllabus. Although 'the greater part' of training is undertaken in a Neurosurgical Department, time in neurology, radiology, spinal injuries or in research may be approved. Trainees are required to attend six-monthly training seminars that are rotated around the training centres.

For each trainee, the Board of Neurosurgery indicates to the Censor-in-Chief its approval or otherwise of the duration and quality of the training program. At the commencement of the period of advanced training, the Supervisor of Neurosurgical Training prepares a program for the training period and

submits it to the Censor-in-Chief. This is to allow for prospective approval of any variations in the program.

The Board has clearly specified the criteria for accreditation of units. Under some circumstances, the Board will consider training in private hospitals.

The *Guide to Surgical Training* indicates that there are 42 posts approved for advanced neurosurgical training in Australia and New Zealand, with posts approved for periods ranging from two years to six months. Based on these figures, the program could accommodate at least 12 trainees each year for the five years required for advanced trainees. In 2001, there are 32 advanced trainees in clinical posts around Australia, one in New Zealand and two in Singapore. This number is marginally below AMWAC recommendations, whereas the number of posts accredited by the Neurosurgery Board of Studies is above that number. There are presently difficulties recruiting trainees to the neurosurgery program, and some concerns were expressed about the variable calibre of the applicants for advanced training. The Chairman of the Board considered that this related to the arduous training and life-style for neurosurgeons with current medico-legal concerns about indemnity as another significant distraction.

Advanced Surgical Training in Orthopaedic Surgery

The Board of Orthopaedic Surgery, which works with the Federal Training Committee of the Australian Orthopaedic Association and its regional Boards of Studies, supervises training. This is a four-year program of which three years must be spent in one specified training program. One year may be spent interstate or overseas in posts arranged by the Australian Orthopaedic Association or one of its regional Boards of Studies. The enthusiasm and dedication of members of regional Boards of Studies impressed the Team.

There are about 140 accredited training posts in Australia and New Zealand and the number of orthopaedic surgeons produced each year is in line with AMWAC recommendations. Selection for training is done by each regional Board of Studies and the methodology differs significantly across regions. The Australian Orthopaedic Association is committed to the establishment of an Australia-wide selection process. All trainees spend time in unaccredited positions (up to four years) before entering accredited advanced training. In some regions the local regional Board of Studies allocates these positions.

The syllabus for advanced training as represented in the RACS *Guide to Surgical Training 1996* is a relatively short list of topics and concentrates on surgery, anatomy and physiology, but a more detailed document is available from the Australian Orthopaedic Association. An examination in Orthopaedic Principles and Basic Sciences is taken in the first year of training and consists of two multiple-choice papers. Representatives of the Australian Orthopaedic Association on the RACS Court of Examiners set this examination; it has a high pass rate. The Australian Orthopaedic Association sets a formal series of lectures which is delivered in each region. Attendance is compulsory. Unaccredited trainees do not have access to these lectures.

Regional Boards of Studies accredit training posts. The Australian Orthopaedic Association determines the criteria for accreditation.

The Team visited several hospitals where budgetary constraints had limited trainees' exposure to expensive procedures such as joint replacement.

Advanced Surgical Training in Otolaryngology - Head and Neck Surgery

To date, the Australian Society of Otolaryngology, Head and Neck Surgery has managed the training program in Otolaryngology - Head and Neck Surgery but has recently agreed that the College should take on this responsibility.

The training program consists of four years in posts approved for training by the special society. Rotation through three hospital posts is required, with the trainee spending normally six month, and no more than twelve months, in any post. A period of six months in research may be approved but continuing clinical work may be required during this period.

The syllabus for advanced training consists of a list of technical requirements. Non-technical requirements, such as those detailed in the CanMEDS document are not included.

The Society organises annually a three to four day registrar conference; which is attended by all trainees in years 1 to 3 of training and some in the fourth year. The conference includes a trial examination and information sessions on changes to the training program.

Otolaryngology - Head and Neck Surgery is a popular specialty. In the last three years, the number of trainees has increased from 40 to 48, which is still short of the AMWAC target for this specialty.

There is a national application process with interviews being conducted on a state basis. In common with other specialties in surgery, selection processes often do not follow Brennan principles.

Trainers in this specialty raised several concerns about changes that may decrease the breadth of the trainees' experience. These included the lack of outpatient exposure in public teaching hospitals in some States, diminished opportunities for post-operative follow up and to participate in the management of some non-surgical conditions now treated principally in private practice.

Advanced Surgical Training in Paediatric Surgery

The advanced training program in paediatric surgery is a six-year program with selection into paediatric surgery at the end of Basic Surgical Training. The first three years involves rotations in adult general surgery equivalent to the first three years of advanced training in general surgery. However, the Board of Paediatric Surgical Training supervises trainees in this part of the program. The three years of general surgical experience may also include other rotations outside general surgery in areas of particular relevance to paediatric surgery, e.g. urology. The second three-year component of the six-year training is in paediatric surgery posts.

There are 19 posts approved for paediatric surgical training, 17 in Australia and two in New Zealand. These posts are generally in the major children's hospitals. The trainees rotate through a number of hospitals with a maximum of one year in any of the smaller centres to ensure a diversity of experience.

There are currently eight trainees in Australia and New Zealand. There is also a number of overseas-trained doctors working in accredited posts, usually with a view to returning to their own countries at the end of their experience rather than seeking Australian registration.

The Board of Paediatric Surgical Training meets annually with each trainee individually to discuss progress, program and areas of interest.

There is an examination at the end of the three-year general surgical training component. In addition to phased development of surgical skills and experience, trainees are required to undertake three written projects per year during the three-year paediatric-specific component of the program. These projects have the generic title of 'critical analysis in paediatric surgery' and are designed to increase the emphasis on evidence-based practice, and to ensure that the educational experience covers all aspects of paediatric surgery.

Advanced Surgical Training in Plastic and Reconstructive Surgery

The plastic and reconstructive surgery program runs for four years after a required year of general surgical experience in an approved hospital post. Trainees are rotated every six to 12 months through a range of posts that are regionally based with the possibility of exchange with a trainee from another region for a period. Trainees are exposed to a range of disciplines including general plastic surgery, reconstructive surgery, microsurgery, surgical oncology, paediatric surgery, hand surgery, and faciomaxillary surgery.

There are groups other than the RACS that provide training in areas such as cosmetic surgery and oral and faciomaxillary surgery. The Board is strongly endeavouring to maintain trainee exposure to cosmetic surgery and faciomaxillary surgery.

The Board arranges accreditation visits to training sites and also reviews logbook records from trainees. There has been a significant effort to create additional accredited positions and to expose trainees to cosmetic surgery principally via training in the private sector. It is estimated that 20 to 30 per cent of positions currently have some time spent in a private consulting or theatre environment. Trainees and supervisors were positive about this initiative.

Both trainees and trainers expressed concerned about the lack of outpatient exposure in teaching hospitals. In this surgical discipline, a large component of the practicing surgeon's work takes place in ambulatory settings where preoperative assessment experience and counselling skills are critical. The Team commends the Board for its creative efforts in attempting to ameliorate this problem.

Trainees are encouraged to undertake research during the training period, and several trainees or recent Fellows are currently undertaking research degrees. Provision is made for trainees to take time out of the program if necessary.

The training program is very popular and attracts a large number of applicants each year. In response, the Board has sought to make the selection process fair and transparent whilst attempting to maintain the necessary discriminatory ability. Each applicant is assigned to a member of the selection panel, who provides a detailed assessment of the candidate. The panel contacts a range of people who have worked with the candidate. These people are not identified and their comments are not provided to the candidate. The candidates and the selectors found this process stressful.

There is a belief that candidates are better prepared if they are experienced in plastic surgery before entering the program. This leads candidates to take up unaccredited positions. This varied across

regions and appeared more common in New Zealand. In some regions, commendably, this belief has been discouraged and the local section has been active in accrediting suitable positions and advising that other positions be downgraded.

Overall, plastic surgery trainees were very positive about the range of experience and the program in general. They clearly recognised the commitment of their supervisors to the training process.

Advanced Surgical Training in Urology

Advanced training in urology is organised and administered by the Board of Urology of the RACS and the Training, Accreditation and Education Subcommittee of the Urological Society of Australia.

Trainees spend a minimum of four years in a urological accredited training post. At least three of these years are spent in Australia or New Zealand, including one year in a country post. The fourth year may be spent overseas in an accredited post, usually the UK, USA or Canada, or in a research post.

Trainees must have first completed two years of basic training and have achieved reasonable proficiency in bowel surgery and laparoscopy. Currently this training is usually achieved by spending a year in a general surgery post, but it is hoped that the introduction of the basic skills workshops in the BST Program will decrease this necessity.

Trainees must complete a logbook and are subject to six-monthly reviews. The training course may be extended if these reviews are unsatisfactory. Trainees sit a multi-choice examination each year, which is used as a guide to progress.

Training supervisors are appointed by the hospital, but are answerable to the State Committee. Accredited posts are seen to be very important to the hospital administrators and the visiting medical staff. In general, supervisors are carefully chosen and encouraged to take their responsibilities seriously.

There are two major issues confronting the Board. One is the diminishing number of outpatient clinics with attendant loss of experience for trainees, both pre-operatively and post-operatively. This is a particular problem in NSW.

The second issue, which is not unique to this specialty, is the diminishing clinical experience due to workplace agreements leading to shorter working hours for trainees with a consequent decrease in the continuity of care, and decreasing elective surgical operating lists as these lists are increasingly committed to emergency surgery.

Advanced Surgical Training in Vascular Surgery

Vascular surgery has only recently (1996) changed its position from post-fellowship Certificate to a Fellowship discipline in its own right. There are 17 accredited training positions of which 16 currently hold a designated vascular trainee. In 2000, there were 23 applicants for 10 positions.

The five-year program includes two years of general surgical training (in approved general surgical positions) followed by three years in positions accredited by the Vascular Surgery Training Program. Trainees are expected to become 'familiar with all aspects of the specialty, including the assessment of patients and operative surgery. Experience in the techniques used in vascular laboratories will be required.' A syllabus has been described and this deals with aspects of the discipline-specific content requirements for both advanced training, eg the syllabus for the basic sciences:

1. Basic surgical techniques
2. Haematology in vascular surgery
3. Haemodynamics
4. Vascular biology
5. Imaging
6. Endovascular
7. Biologic response to materials in vascular surgery

The syllabus for basic and advanced training serves as a specific checklist of anatomy, pathology, physiology, diagnostic modalities and clinical syndromes rather than a curriculum.

In-training assessment follows the model of a formative mid-term assessment and a summative assessment at the end of each six-month term. As with the General Surgery in-term assessment, trainees are required to reach a level of competence in each of the domains assessed and failure to do so triggers counselling and remediation at the supervisor level. In the event of persistent failure to meet the minimum standard, the term would not be regarded as contributing to training.

Vascular trainees are examined at two stages in their training. An examination in Basic Vascular Principles Techniques and Devices is completed 'usually' in the first year of vascular training. The Fellowship is undertaken in the third year of vascular training on the recommendation of the supervisor. The Fellowship examination is conducted in much the same way as the General Surgical Fellowship examination with written and clinical components. Examiners have been chosen from those vascular surgeons who were on the General Surgery Examination Board at the time when the Vascular Fellowship was first set up. The validity of this examination needs to be assessed.

Recommendations relating to Advanced Surgical Training Programs

- *A 'start up' package of information would greatly assist new training supervisors.*
- *A comprehensive system for providing robust feedback needs to be developed. This should include a detailed reporting mechanism with assessment criteria, assessment forms to facilitate the process, and a formal mechanism for providing descriptive and specific assessment information to trainees, indicating their professional strengths and areas for improvement. Expectations for optimal performance in the operating room, on the wards, and in the clinic should be written for various levels of training.*
- *Regular workshops are needed for training supervisors to assist with key supervision tasks, particularly in how to assess performance more effectively. Trainees should be encouraged to participate in these workshops.*
- *A system for identifying trainees 'at risk' should be implemented, preferably in the early stages of the program. Such a system should provide goals and support for these trainees to improve.*
- *Trainees would appreciate workshops to provide them with practice in examination techniques.*
- *The College should continue to use its influence in alerting State Governments to the problem of the decreasing clinical experience of trainees and encourage the re-introduction of outpatient clinics and improved elective operating lists.*

EDUCATIONAL PROGRAMS

The RACS has moved to structured education programs in a number of areas, and the Team commends its endeavours. The new BST Program, described earlier, is the most obvious example. The implementation of the new BST represents a major advance in surgical education and in the College's relationship with its trainees. It is planned to introduce this structure for the trainees in Year 3 and Year 4 of BST. This is highly desirable.

The courses for Basic Surgical Trainees are designed to be delivered in a variety of centres, including the three skills centres. In addition to the direct costs of the skills courses, which are a source of disquiet amongst BST trainees, there will be travel and accommodation costs for trainees working away from the centres offering the courses. It is too soon to comment on the effect of these courses on Basic Surgical Training but the Board of Basic Surgical Training should continue to evaluate this.

RACS has collaborated with the University of Melbourne to provide a Postgraduate Diploma Course in Surgical Anatomy, which Basic Surgical Trainees can choose to take. Shorter anatomy courses are planned in collaboration with other universities in other States.

The Advanced Surgical Training programs also contain a range of courses aimed at advanced trainees. Several of the nine Advanced Surgical Training programs require their trainees to attend various meetings and courses during advanced training. These courses are provided primarily by the Specialty Societies on behalf of the relevant Board of Studies. The Team was not given details of these courses.

Trainees are encouraged to attend the College's Annual Scientific Congress and are offered a reduced registration fee.

Learning aids

The Team congratulates the RACS on its innovations in delivering aspects of training and supporting trainees and supervisors.

One such innovation is the development of a training simulation model. In partnership with the University of Western Australia, the College has developed a Collaborative Training and Education Centre, (CTEC) which is refining the simulation model. Similar skills centres are planned for both Melbourne and Sydney. These centres will also play a role in the continuing professional development of Fellows. Whilst the introduction of these centres is an exciting innovation, the costs are very high. The educational value of these innovations needs to be assessed and their use extended

to undergraduate and other areas of postgraduate education. Less expensive skill centres should also be developed and evaluated.

Although the College is using the Internet to provide information and resources to trainees, there has been little formal evaluation of how these resources can be developed to better meet the educational needs of trainees. Some trainees were unaware of or reported difficulty in gaining access to the RACS website in their workplaces, where access can be restricted due to hospital firewalls or lack of hardware in clinical areas. The College criteria for accreditation of hospitals/ training posts require that trainees have access to educational resources including a medical library and IT facilities. If RACS is to use web-based material to support training, then it would be appropriate for Internet availability to be verified during hospital accreditation visits.

Some trainees expressed concern at a loss of resources previously available on the website, such as access to full text electronic copies of key journals. In New South Wales, access to support material for the State-based tutorial program for advanced trainees in general surgery was also a concern.

Recommendation

That the College develops a formal continuing process of evaluation of skills centres and Internet-based training and education material.

RESEARCH IN TRAINING

The Royal Australasian College of Surgeons demonstrates a commitment to 'advance surgical knowledge and care through research and development' *(RACS Strategic Plan 2000-2005)*. The Board of Surgical Research has oversight of the College's research endeavours, which include the John Mitchell Crouch Research Institute and numerous Fellowships and Scholarships for full-time and part-time research (these having a reported outlay exceeding $1.5M for the most recent financial year).

The program literature for BST makes no mention of research, and research activity is not included in the *Trainee Assessment Form*, though it does receive a mention in the *Basic Surgical Trainee Experience Portfolio* form. Interviews with Basic Surgical Trainees would suggest that research has relatively low priority in comparison to completion of the core elements of the BST Program. There was considerable uncertainty however, about whether or not research was a prerequisite or an advantage for gaining entry into an Advanced Surgical Training program. Furthermore, though the

general sense among BST trainees is that research helps to get AST places, there is confusion regarding how much research and of what type.

Recommendation

That the College states more clearly the value of research activity during pre-AST years in securing AST positions.

Concerning Advanced Surgical Training programs, the *Guide to Surgical Training* states that, 'an investigative project is mandatory for all Surgical Trainees prior to presenting for the Part 2 FRACS Examination'. The level of this research can vary from oral or poster presentation at a State College meeting, to achievement of a high academic degree or a recognised period of full-time research. While it is clear that demonstrated research capability is an important component of achieving fellowship, the range and nature of this research, and its evaluation, could perhaps be made more explicit and rigorous. This would assist candidates, supervisors and mentors in planning the research component of each AST trainees program.

Finally, with respect to continuing professional development, the Information Manual 2001 briefly outlines various ways in which research related activities can contribute, and the process for verification.

4 ISSUES RELATING TO TRAINEES

SELECTION OF TRAINEES

In 1998 the Medical Training Review Panel commissioned Dr P. Brennan to review the selection processes of the colleges and to develop a 'best practice' framework for trainee selection.[4] This is summarised as:

- There should be a clear statement of principles that underpin the selection process.
- There should be a clear statement of eligibility to apply for, and be selected for, training.
- There should be a national awareness of opportunity for all eligible candidates.
- Quotas, if applicable, and limits relating to other factors, such as the number of training position, should be explicit and openly declared.
- Referees' reports should be pro forma with a view to achieving, objectivity, comparability and quantification.
- The Selection Committee should have the confidence of the candidate, the profession and the community. It should be prepared to be held accountable for their decisions with the size of the Committee proportional to the task. Its members should be prepared for their processes and decisions to be reviewed in other forums. The selection process should be valid, reliable and feasible with evaluation built into the process.
- The selection criteria should be documented and published. To the greatest extent possible they should be objective and quantifiable.
- The interview should be objective and free of bias.
- The selection process should be based on the published criteria and the principles of the College concerned whilst also being capable of standing up to external scrutiny.

[4] 1998 *Report to Medical Training Review Panel 'Selection into Specialist Training Programs'*

- Adequate documentation enables external scrutiny, audit and evaluation of the selection process. It should enable accurate reconstruction of the original detail and process.

- Candidates should be given or at least offered a frank appraisal of their standing in the eyes of those conducting the selection process.

- There should be a formal, regular inclusive review of the process.

- There should be a formal process for reviewing/appealing decisions in relation to selection.

The Brennan framework envisages a partnership between colleges and employing authorities in the setting of modern principles of human resource management. Selection into both basic and advanced training programs is critical for trainees and for all the colleges. Most colleges have now adopted the Brennan principles for selection into specialist training programs.

The Royal Australasian College of Surgeons has devoted considerable effort in an attempt to meet the Brennan principles. It has significantly changed its selection processes in recent years, introducing changes that are universally regarded as improvements.

The selection process for trainees wishing to enter the Advanced Training Program in General Surgery comes close to satisfying Brennan principles but would be improved by adding to the selection panel representatives of employing authorities and members other than surgeons. More effective feedback to unsuccessful applicants would also be helpful.

The Team believes that adherence to the spirit and practice of Brennan selection principles is imperative. All sections of the College should implement these principles and adherence to these principles should be part of the Heads of Agreement between the RACS and special societies recommended earlier.

Recommendation

That the College review all its selection processes to ensure that the College adheres to the above principles within the next 12 months.

That adherence to these principles be part of the Heads of Agreement between the RACS and the special societies.

The RACS selection process involves explicit consideration of four main elements:

- the candidate's curriculum vitae;
- referees nominated by the candidate;
- the results of the interview.

In the past there was virtually no selection process for basic trainees and, for some subspecialties, a quite intimidating large group interview for advanced training. The interview component of selection is extremely important, in part because differences between candidates on other considerations may be minimal.

Basic trainees now face a structured interview, where the interviewers have been trained formally in the process.

Some special societies use verbal references from persons either nominated by the candidate or selected by the interviewing panel. Importantly, informal feedback is sought not only from surgeons but also from other hospital staff who may have worked closely with the candidate (e.g. theatre nurses). Although the use of these informal referees is said to be widely known and understood by candidates, it does not appear to have been made explicit as part of the advice to candidates.

The interviewing process involves a varied number of Fellows interviewing the candidates. An increasing number of the interviewers have been trained in structured interviewing. For basic training, the panel could include members from outside surgery (e.g. other medical practitioners who work with surgeons such as general practitioners, or consumers) and representatives of employers. For advanced training the panel might include surgeons from other subspecialties thus taking advantage of their expertise, emphasising the College's role as an integrator across surgical subspecialties while helping to ensure the transparency of the decision-making process. This might also increase the emphasis in selection on generic surgical skills rather than experience in the subspecialty. Representatives of employing authorities interviewed by the Team often voiced feelings of disenfranchisement because they were not included in the selection process. For advanced trainees, the special societies adopt a range of interviewing approaches. Some specialty boards should consider reducing their panel size.

Recommendation

The College should review the operational rules and composition of selection committees for both basic and advanced training.

At present the College aims to select candidates for advanced training as early as possible after graduation. In particular, the College has indicated its wish that basic surgical training commence with the second postgraduate year. This means that candidates must apply for basic surgical training half way through the first postgraduate year (intern year). Although many newly graduated doctors will have identified surgery as their chosen vocation early in their student career, many will not have had an experience of a surgical term by the time they are expected to make a decision about basic surgical training. The College may also find it difficult to assess candidates properly in the absence of a range of surgical referees and may be discouraging some junior doctors from applying for training. The College may be restricting its pool of potential applicants of high quality by these policies.

Postgraduate Medical Councils, in the design of the first two postgraduate years for medical graduates, have been encouraging Colleges to move to a selection process at the end of the second postgraduate year rather than the end of the first postgraduate year. The Royal Australasian College of Surgeons may be able to accommodate this direction by changing its processes for recognition of surgical training by allowing retrospective recognition of second year posts. Although some rescheduling of the required courses would be needed, such a process would still allow selection at the end of the second year whilst not prolonging surgical training.

Recommendation

That the College consider changing selection of basic trainees to allow retrospective recognition of second year posts.

The subspecialties are moving increasingly towards national or state based training programs. This has a number of advantages, the trainees are exposed to a broader range of surgeons and peripheral hospitals are now staffed with higher quality registrars. Nevertheless, the move from local to statewide or national training has some disadvantages, including that trainees may have a lower level of attachment to a particular hospital. This disadvantage could be offset by the College developing a mentoring arrangement where a trainee has an identified mentor with whom the trainee could discuss a broad range of issues including the overall shape of training, or a problem with a particular supervisor. Although the state supervisor of training may formally have this role, especially in the longer training programs, trainees are unwilling to burden the supervisor with any issues that may arise.

Recommendation

The College and the subspecialties should implement a mentoring program for trainees.

Although there is a general policy about feedback to unsuccessful candidates, trainees reported that in practice the availability of feedback was variable. Feedback is critical to guiding candidates in their career planning, and a lack of detailed feedback contributes to poor understanding of the requirements.

TRAINEES WITH INTERMEDIATE STATUS

For many years there have been more aspiring surgeons than available training places and traditionally those unsuccessful in gaining admission to advanced training have occupied so-called non-accredited posts. Non-accredited posts are hospital positions at resident medical officer or registrar level that have either not fulfilled the College's criteria for accreditation or for which accreditation has not been sought by the employing institution. Surgical trainees who have not yet passed the Part 1 examination also hold these posts, as do medical officers not committed to surgical training. This section concentrates on those who have successfully completed the BST and who are waiting for selection for advanced training, trainees with intermediate status.

Under the old BST scheme there are 260 trainees who are qualified and expected to apply for advanced surgical training this year. There are somewhat more than 400 trainees who remain registered and have until the end of 2003 to progress to advanced surgical training before their qualifications lapse. The current availability of advanced training positions is 172 each year. Under the new BST Program there are 169 trainees (202 were selected for entry in January 2000). Of these, 90 have registered to take the summative assessment enabling progression and a maximum of 60 will be eligible to proceed to advanced training.

The Team perceived four major issues concerning trainees with intermediate status:

Could experience in non-accredited jobs be credited for training?

Many trainees in these positions believed that the experience was valuable and helped prepare them for advanced training but indicated that the level of responsibility and operating experience was less than that given advanced trainees. Others believed that the experience and training were equal or

superior to that of accredited posts. The value of a non-accredited position appeared to be dependent not only on the range of clinical conditions encountered but also the enthusiasm and commitment to teaching of the immediate supervisor. Several supervisors explained that they were not able to spend time teaching trainees with intermediate status either in the operating theatres or wards. In some institutions trainees with intermediate status did not have the time, or were discouraged or prevented from attending formal educational sessions.

Currently, certain subspecialties limit the access to educational opportunities for non-accredited trainees or exclude them altogether. It appears incongruous that the critical early experience in some fields is gained in a non-training post where the trainee is not permitted to attend educational sessions. This is difficult to support.

The *de facto* prolongation of the duration of surgical training for many trainees is a major concern to them. It appeared to the Team that at least some non-accredited posts might have potential for training and it is pleasing to hear that the Chairmen of the Advanced Training Boards have been directed to identify all possible training posts throughout Australia.

The numbers of trainees involved

Entrance to advanced surgical training is achieved by successful completion of the Part 1 FRACS examination and selection into an Advanced Training Program. Until recently the Basic Surgical Training Program was unstructured but, as discussed above, BST is now a two to four-year structured program during which trainees complete three skills courses, a group of modules delivered by distance education, a multiple choice examination and an OSCE. 2000 was the cut off for new applications into the 'old' BST Program and these have until 2003 to complete BST.

There appear to be about 700 trainees under the 'old' BST system planning to enter advanced training and about 450 trainees enrolled in the 'new' BST system. There are about 625 Advanced Trainees in the various College programs of whom about 120 graduate each year. Very few leave the program other than by graduation. Thus even if additional training posts were identified (and it is unlikely that this could increase numbers by more than a few percent) there will be a major shortfall in advanced surgical training posts. Many of those in the 'old' BST Program believe that their difficulty in gaining advanced training posts will be compounded by the need to compete against better prepared trainees from the 'new' BST Program.

The large numbers of trainees seeking advanced training is a major issue for the College. The College is actively investigating the practicability of aligning more closely the numbers entering Basic Surgical Training to the numbers of available advanced training positions and the Team commends this. The logistic challenges in achieving this goal of 'seamless' transition from Basic to Advanced Surgical Training are however considerable.

The Team commends the decision to direct Chairman of the Advanced Training Boards to seek out all possible new advanced surgical training posts. This may be facilitated by review of the criteria for accreditation of Advanced Surgical Training Positions and review of those positions that were close to accreditation.

The trainees' relationship with the College

At present trainees with intermediate status have no formal relationship with the College. Their major needs for advice and support were obvious to the Team, which noted the practice of the Queensland Branch of the Australian Orthopaedics Association to mentor these trainees and to facilitate their access to non-accredited posts. The Team believes that the College needs to develop methods for helping these trainees prepare for the process of selection for advanced training and for advice in seeking alternative career choices.

Selection of posts and experience

The Division of General Surgery has moved to facilitate the transition between BST and AST and encouraged applications from candidates in their second BST year. Subspecialties such as plastic surgery, urology, cardiothoracic and otolaryngology - head and neck surgery require or strongly encourage a period of general surgery prior to entering the program.

Increasingly, candidates for these fields apply from an accredited general surgical position. This means that they can continue in an approved general surgical training program if they are unsuccessful in their application. There is a significant group who have chosen to remain in general surgery so whilst the program loses a number of trainees, it also gains trainees in this way.

Most candidates and trainees interviewed by the Team indicated they would consider applying to more than one specialty program or to changing their intended program for an application in a subsequent year. In view of the undersupply in certain subspecialties and the oversupply in others the College

might explore increased flexibility at this level and encouragement for trainees to consider redirecting their choice if they wish.

Recommendations:

That the College continue moves to ensure that the transition from basic training is seamless.

That the College's progress on ensuring appropriate transition from basic to advanced training should be subject to further review as part of the next AMC accreditation.

That trainees under the 'old' BST system seeking entrance to Advanced Training Programs should not be disadvantaged in the selection process.

That the College should develop methods for advising and mentoring trainees with intermediate status about career choices.

TRAINEE REPRESENTATION IN COLLEGE AFFAIRS

The College and its Fellows invest considerable time, resources and effort on trainees and their training. The Team was very impressed by this high level of commitment.

In general however, trainees appear to feel distant from College authority and affairs. Advanced trainees in many areas view the relevant special society as the principal and active body in their training. This may reflect the relative independence of some special societies and the low levels of trainee contribution to the development of training and assessment policies and programs.

Trainee representation varies widely across subspecialties. Although a Registrars Association exists, most trainees were unaware of it and the Association did not appear to be involved in College affairs in general. Much trainee feedback is by unofficial channels, for example at yearly academic meetings and interviews with the training board. Trainees reported some discomfort at presenting information in these settings.

There is a number of areas of College activity where official involvement of trainees could be considered, such as:

- subspecialty regional and /or national boards;

- committees dealing with the well being of trainees;
- the Censor-in-Chief's Committee/Board of Advanced Surgical Training;
- Basic Surgical Training committees;
- selection committees.

Recommendation

That the College considers mechanisms for improved communication with trainees and incorporation of the views of trainees in education and training policy development.

WOMEN IN SURGERY

The RACS is committed to expanding the number of women in surgical training, and to ensuring that training programs do not unnecessarily disadvantage them. The development of the Women in Surgery Committee and the Mentoring Program reflect that commitment. Attracting females to pursue surgical careers is not a problem unique to Australia, but since half the Australian medical graduates now are female, and there is a need to continue attracting the best graduates to surgery, attention to this challenge is of utmost importance.

The Team makes the following suggestions concerning ways in which the College might further expand the number of women in surgical training:

1. All trainees should have mentors, preferably geographically close. Short curriculum vitae of the mentor and trainee could be forwarded to each other in advance and the paired individuals could then determine the extent and frequency of contact. An evaluation of the program should be planned that encompasses the perspectives both of trainees and mentors.

2. Woman may prefer female mentors and the College could consider expanding the availability and numbers of female mentors by recruiting women from both the RACS and other Colleges, for example the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

3. The RACS website should include a section for Women in Surgery listing Frequently Asked Questions (FAQs) and corresponding answers. The Women in Surgery Committee should hold a focus group discussion with current and past female trainees to determine the content.

4. The College could consider a 'Women in Surgery' annual meeting to enable mentors and trainees to meet. Topics for presentation could be based on an information and skills needs assessment conducted by the WIS Committee, and could include clinical areas as well as topics such as conflict negotiation, communication skills, women's health issues, etc.

5. A strategic plan should be developed to encourage young women to consider a surgical career. This might include increasing women surgeons' involvement in medical school 'Career Days' where they exist and developing a videotape that describes the profession, addresses commonly held lifestyle myths, and identifies options for further exploring surgery as a viable career for women. This could be distributed to libraries, secondary schools and medical schools.

6. Few trainees undertake part time training and the Policy on Part Time and Interrupted Training needs review, especially exploring reasons for its limited use. This could be a focus of discussion at the proposed annual Women in Surgery Program. Its actual acceptance, availability, and consequences should be explored. If trainees can remove themselves from the clinical environment to pursue research without adverse consequences, then men and women should be able to take a full or partial year off for family reasons without compromising their position in the training process. Supervisor and trainer attitudes toward this might be explored to ensure appropriate support and understanding.

7. A small handbook ('Pocket Mentor') may be developed that outlines practical tips for every trainee starting their training, including advice in specific areas (pregnancy, harassment, prejudice) beyond traditional 'service work' advice. Useful examples are available from the USA.

8. Female surgeons should to the extent possible involve themselves with junior medical students as early on in their education as possible. It is important for young women to be exposed to female role models as they begin considering their career selection. Many myths exist regarding surgery as a profession for women, and these need to be dealt with early in the medical education process.

9. A policy should be in place for women in advanced surgical training who become pregnant and need time away. Some other Colleges and many hospitals have specific guidelines for parental leave.

The Team acknowledges that not all women surgeons may qualify as 'role models' or would necessarily make good mentors, nor does it mean to imply that male surgeons supportive of advancing the number of women in surgery could not serve in the roles described above. Careful selection is needed however to ensure that positive, consistent, and appropriate information is made available to prospective and current women in surgical training in order to increase the number of women in the surgical disciplines.

5 ASSESSMENT AND EXAMINATION

ASSESSMENT IN BASIC SURGICAL TRAINING

The comments pertaining to Assessment and Examination in Basic Surgical Training are based upon the following predicates:

1. 'Summative assessments are the traditional examinations that count towards the 'final marks'; whereas the sole purpose of formative assessments is to let the students know how they are progressing. Formative assessments allow students to detect under achievement at any early stage and instigate some form of remedial action.' (Hamdorf, Hall, ANZ J Surgery March 2001)
2. Trainees are entitled to performance feedback in such a way that any necessary remedial action may take place without the potential to compromise progress.
3. Formative assessment should be a formalised process.

The *Guide to Surgical Training 1996* sets out in detail the components of the assessment and examination package for Basic Surgical Training, and the rules relating the conduct of the Part 2 FRACS Examination. From the information provided by the College, it appears that it does not have a formal and explicit statement of assessment and examination policies to guide the development and implementation of assessments and examinations.

As noted previously, the Board of Basic Surgical Training has established a set of objectives for the Basic Surgical Training, but these are not supported by explicit educational goals. At a time when the BST Program is undergoing change, it is important that the objectives of the training are clearly articulated so that the assessment can, as necessary, be modified to reflect these changes.

The roles of medical expert, communicator, collaborator, manager, health advocate, scholar, and professional, as articulated by the CanMEDS project, offer a useful framework to consider including the non-technical aspects of surgical training in training and in assessment.

Formative assessment or performance feedback

Some formative assessment is provided during the clinical rotations undertaken by the trainees, and from the skills courses and the final examinations.

The Basic Surgical Training Experience Portfolio records the breadth and depth of training received by the trainee and is forwarded to the College at the conclusion of the rotation. Although the College states that the portfolio 'permits an audit of … performance' the Team has difficulty in understanding how this can offer timely performance feedback to the trainee.

The College's information to trainees indicates that obtaining in-training formative feedback is the responsibility of the trainee. The College's accreditation submission to the AMC indicated that gaining formative assessment is primarily the responsibility of the trainee but that the hospital supervisor is also responsible through monitoring various educational activities. The Team's site visits revealed that formative assessment is variably applied, ranging from regular interviews between hospital supervisors and trainees to situations where the trainees were unaware of the identity of the supervisor.

Trainees generally undertake the MCQ summative assessment during the second year of basic training, and self-directed formative assessment is available. Trainees can obtain, through the Basic Training Web page, 1500 questions from the examination bank. Feedback is restricted to the correct answer and reference to the prescribed text from which the question was sourced. In addition the College has supported the production of a book *Multiple Choice Questions in Basic Surgical Sciences (Buzzard and Bandaranayake),* which allows further self-directed formative assessment.

The three BST skills courses also contain elements of performance feedback. In the Basic Surgical Skills Course, tutors are expected to offer continuous feedback to the trainees and are instructed in these skills in their pre-course training. There is no summative assessment. In the event that trainees do not meet the required standard, remedial tutoring occurs during the course. Since the implementation in October 1998 of the pilot courses and in January 2000 of the mandatory BSS course, the only unsuccessful participants have been those who have not attended the entire course.

In the Early Management of Severe Trauma course, trainees participate in skills stations and undertake continuous summative assessment. Trainees not meeting the required standard are offered immediate remediation. Participants who are persistently below standard may need to repeat a station at a subsequent course. Formative assessment is presented in two formal settings. Trainees complete an open book MCQ before the course, which is graded and returned to them. The range and difficulty of this pre-test reflects standards of the final summative MCQ. The clinical summative assessment at the end of the course is preceded by two episodes of formative assessment with feedback being offered by the instructor.

The Care of the Critically Ill Surgical Patient course also has substantial amounts of formative performance feedback and some summative assessment. In the EMST and the CRrISP courses, trainees failing a component may be allocated a conceded pass, a further attempt at a component of the summative assessment test under examination conditions, or be required to repeat the course.

Summative assessment

The MCQ examination and the OSCE are the two major components of assessment used to determine progress in the Basic Surgical Training Program.

The MCQ may be taken in the second year of training, the stipulation being completion of the STEM modules. As this distance-learning program comprises 22 self-directed learning modules that are not assessed, the receipt of the modules from the College is effectively the only prerequisite.

The MCQ consists of three papers of 120 questions drawn from the three basic science disciplines of physiology, pathology and anatomy. Each area has a separate question bank and the discipline groups are responsible for the formulation, validity and reliability of the questions. There is no external referencing. The Team noted little integration between the three domains, and the Board of BST should explore ways of facilitating integration.

A recent change to a non-penal marking system has increased significantly the number of passing candidates. The Team urges the Board to continue its evaluation of the performance of trainees in this examination.

The MCQ was the subject of an external review of process undertaken by Professor Bernard Rechter, formerly of the Australian Council on Educational Research and Monash University, which found the MCQ examination to:

- be too difficult;
- use penal marking which was 'difficult to justify legally';
- have an unsatisfactory method for determining the cut-off point;
- be largely reliant on knowledge recall rather than analysis - promoting the memorisation of facts;
- lacking in item discrimination analysis reflecting reliability and validity, adequate pre-testing of questions.

To date the Board of Basic Surgical Training has acted on one of the report recommendations, by removing penal marking. It was not clear to the Team whether implementation of other recommendations would follow.

The Team urges the Board of Basic Surgical Training to give serious attention to the examination blueprint, quality of questions, and psychometric integrity of the examinations, with the professional assistance of individuals experienced in medical standardised testing. These are high stakes examinations, and passing criteria must be understandable and clear to supervisors, trainers, and trainees. The standard setting system needs careful scrutiny.

A semi-structured interview is mandatory for all candidates completing the MCQ. The College indicates that this is to identify issues such as poor health that may have influenced the trainee's examination performance and that a summary of any relevant issues is provided to the examining Board to consider when reviewing results. Trainees appear to be uncertain of the purpose of this interview.

The Objective Structured Clinical Examination (OSCE) is taken after the MCQ examination has been successfully negotiated and is seen as an exit exam from Basic Surgical Training. This exam consists of 20, five-minute stations. A number of the stations, generally 12, require an assessor to be present whilst the remainder are not supervised.

Trainees have access to a Learning Guide for the OSCE examination and this provides a comprehensive guide to the nature of the examination as well as containing examples of the examination station conditions. The psychometrics of the OSCE also requires continuous monitoring to ensure a fair process and reliable scores.

Trainee guides to assessment

As indicated in the section on Basic Surgical Training, there is not a curriculum or clear educational objectives for Basic Surgical Training. Trainees are provided with a reading list to guide them in their preparation for the MCQ, which has recently been revised and reduced. Nevertheless it is a list of books to be read rather than a curriculum or list of objectives.

Much of the information used by trainees is propagated by 'word of mouth'. Where trainees receive information from a range of official and unofficial sources, a 'hidden curriculum' can develop;

examination preparation courses emerge which teach trainees how to pass the exam once they have learnt all the material in the syllabus.

Procedures concerning unsatisfactory performance

The College submission described a variety of procedures for giving feedback to candidates on unsatisfactory performance. These appear quite reasonable, but the Team's interviews with trainees and supervisors suggest that they are not enacted systematically. It was apparent that supervisors lack training in their roles and responsibilities although courses such as Surgeons as Educators do specifically address the role of assessment and feedback. There seemed also to be a lack of appropriate emphasis on the 'humanistic' side of surgical training by both trainees and supervisors.

Recommendations

1. *That the examination discipline groups should explore better integration between the three basic science disciplines.*

2. *That the College reconsider the recommendations of the Rechter report.*

3. *That the system of standard setting used in the BST examinations should be reviewed by an medical educationalist who specialises in testing and measurement.*

4. *That a clear set of objectives and a curriculum should be developed for BST.*

5. *That methods for providing formalised performance feedback to trainees should be developed.*

6. *That the College considers how it might incorporate assessment of the broader roles of medical specialists, such as those identified in the CanMEDS framework.*

ASSESSMENT AND EXAMINATION IN ADVANCED SURGICAL TRAINING

The core elements of the Part 2 Examination are outlined in Section 10 of the *Guide to Surgical Training 1996.*

Eligibility criteria for sitting the Part 2 Examination are clearly outlined. Advanced Surgical Trainees must apply to the Censor-in-Chief for permission to participate in the Part 2 Examination. The Censor-in-Chief, in making a decision regarding eligibility, may take into account:

- recommendations of the relevant specialty board concerning satisfactory length and scope of training;
- confidential reports from supervisors of training;
- referee reports;
- information from the logbook.

The examination itself consists of written, clinical and oral sections, and this structure is basically consistent across AST Programs. The content is limited to the published AST Program syllabus.

Trainees may re-present for examination should they be unsuccessful and there is no formal limit to the number of presentations. The Censor-in-Chief must however approve eligibility each time, according to the criteria outlined above.

Trainees and supervisors were generally of the view that the content of the examination fairly reflected the clinical and technical aspects of surgical training. As noted elsewhere the examinations reflect the syllabus in that there is little emphasis on non-clinical roles, knowledge or skills.

Trainees expressed some uncertainty about how eligibility to become a candidate for examination was assessed, and in particular regarding:

- How logbooks are assessed. Trainees do not have a clear understanding of what they needed to demonstrate to optimise their chances of eligibility.

- How confidential specialty supervisor reports might be dealt with. It was felt that the processes must be transparent and fair.

A system that allows concerns of supervisors or problems with logbooks to be uncovered only when eligibility to set the examinations is being considered is faulty. At this stage it is probably too late to establish effective remediation processes. A better formative assessment and feedback process, as discussed previously, would allow earlier identification of problems.

There are opportunities to improve the AST examination by:

- exploring opportunities to broaden the scope of the examination to include non-clinical aspects of Fellowship;
- reviewing and updating the guidelines for the content of the logbook, including exploration of electronic data entry and more frequent review.

Recommendation

That RACS consider incorporating non-clinical material into the Part 2 Examination.

ASSESSMENT OF OVERSEAS-TRAINED SURGEONS

As do all the specialist medical colleges, the Royal Australasian College of Surgeons provides advice to Australian State and Territory medical boards and the Medical Council of New Zealand on the suitability for local registration of specialist medical practitioners trained overseas. In Australia, overseas-trained specialists apply to the AMC, which checks that the application meets standard eligibility requirements, and then forwards the application to the relevant specialist medical college, which assesses the application by comparison with the standards of competence and safety expected of Australian-trained specialists.

The State and Territory medical boards and the specialist medical colleges have jointly agreed that the purpose of this specialist assessment procedure is to assess the equivalence of training and qualifications of overseas-trained specialists with Australian trained specialists. It is not an alternate pathway for entry to specialist training for overseas-trained specialists who the relevant college judges to have significant deficiencies in training.

In its submission, the Royal Australasian College of Surgeons provided summary information on its process for assessing applications, which the Team supplemented by discussions with College staff and office bearers. The Team also met overseas-trained surgeons during its site visit, and surveyed overseas-trained surgeons with an application in progress through the AMC. One-third of those surveyed responded.

In recent years, the College has given considerable attention to standardising and formalising its process for assessing overseas-trained surgeons. The College receives applications from approximately 100 overseas-trained surgeons per year; all individuals go through the same process. Overseas-trained surgeons are required to provide documentation of past qualifications and

experience. A paper assessment is carried out and a file note is made for each applicant. On the basis of the paper assessment the Censor-in-Chief determines who is deemed to be close to registrable and to require a period of practice oversight and/or examination, who will be interviewed, and who will require extensive further training and therefore will not be interviewed.

The interview is semi-structured with two to three interviewers, including the relevant Specialty Board Chairman and the Censor-in-Chief or nominee. The interview process seeks to compare the applicant's level of knowledge and experience to that of an Australian registered surgeon at a comparable level. The interview also seeks to determine the surgeon's level of knowledge of Australian health care and surgical practice.

All successful overseas-trained surgeons are required to undertake a period of 'on the job' assessment for a maximum of two years. The expressed aim of this period is to allow surgeons to demonstrate and consolidate their clinical knowledge, skills and professional practice and to experience a period of acclimatisation to the local health care system. The surgeon is required to maintain a logbook of operative experience, to audit their surgical practice and to undertake a program of continuing medical education. Two Fellows of the College review and report on designated aspects of the overseas-trained surgeon's surgical practice at stipulated intervals. If the surgeon is working in an Area of Need position, oversight may be provided at a distance. The rationale for requiring 'on the job' assessment has not been made clear to the Team. In particular, the Team was not able to understand why some surgeons might not be excused from such experience.

There was variability in the time spent by the surgeons in a period of supervised assessment. College office bearers were clear about the aim of the assessment process, but not all the overseas-trained doctors and Fellows of the College interviewed by the Team shared this understanding. In some instances, this period was regarded as training and was referred to by some as 'lateral entry'.

Despite the considerable work done in recent years to improve the process, the Team identified several areas where the implementation of the College's process can still be improved. The College may find it useful to compare its own experiences and management process with those of similar colleges overseas, as well as with other local colleges.

The principal concern relates to communication with the College. Some overseas-trained surgeons reported delays of several months in replies to correspondence and some inconsistencies in messages from the College, either from personal communication or official documentation. Many indicated that authoritative advice was difficult to obtain. Local Fellows, while willing to provide advice and assistance, indicated to the Team that they were not always well informed on the College's processes

and rules. These matters appeared to be a particular problem for those required to re-train fully or those whose applications were unsuccessful. The Team urges the College to consider its strategies for communicating with overseas-trained surgeons, Fellows and hospitals concerning the requirements and process for assessing the qualifications of overseas-trained surgeons. One strategy may be to appoint a local mentor or advisor for those in the assessment pathway.

The overseas-trained surgeons interviewed by the Team came from a range of countries and backgrounds, and reported variable experience of the process: most variable was the stated time from receipt of documentation by the College until a decision, which was from 72 months to three months. The Team recognises that delays in the decision-making process may result from delays in the candidate's response as well as from delays in the College's processing, and delays that result from reliance on the voluntary commitment of College Fellows' time to the assessment process. It did note however that in nine responses, applicants reported waiting times of 18 months or more. It is hard to see the justification for such a lengthy process. The College would be in a stronger position to respond to criticisms of timeliness if it explained clearly the reasons for each step in the process, for the time required and for delays.

Concerns were also expressed about the validity of the College's process for reviewing past experience.

There is a College-wide appeals process that would permit overseas-trained surgeons to appeal the outcome of their assessment. Overseas-trained surgeons who met the Team lacked knowledge of the process.

In order to complete the required period of on-site assessment of professional practice, the overseas-trained surgeons must obtain a salaried position in an approved hospital. Whilst the College is not responsible for obtaining such positions, nevertheless the lack of quarantined places for overseas-trained surgeons in advanced training is a considerable frustration. This issue is not peculiar to surgery, and may be something that the Colleges should consider jointly.

Recommendations

1. *That the College review its processes for the assessment of overseas training surgeons to ensure that they are uniform between the subspecialties and that the time taken for review is minimised.*

2. *That the College review its strategies for communication concerning the assessment of overseas-trained surgeons, in particular it should:*

    - *consider identifying in each State a mentor or adviser to overseas training surgeons applying through the College for assessment.*
    - *restate the role of the AMC/College pathway for assessment of overseas-trained specialists.*
    - *explain the reasons for the various steps in the process.*

6 ENVIRONMENT FOR TRAINING AND TEACHING

COLLEGE ACCREDITATION OF HOSPITALS AND TRAINING POSITIONS

The College's accreditation process includes accreditation of the unit within which a basic trainee would work and accreditation of posts that could be occupied by an advanced trainee. Regardless of which approach is used, the accreditation process involves two major elements. First, hospitals provide certain base data about the hospital, the relevant surgical unit, including its caseload, and other elements of hospital activity.

The second component is a visit by an accreditation team. The accreditation visit examines a range of matters (also generally covered in the data collection referred to above) including:

- information about the infrastructure and environment of the unit including library facilities, quality assurance processes including morbidity and mortality reviews, etc;
- information about the casemix (both number and type of cases);
- opportunities for the trainees to receive experience in a range of elements of patient care such as outpatient clinics (to provide experience on clinical process to recommend surgery and for post-surgical follow-up), number of theatre sessions that the trainee will be able to attend per week etc.;
- supervisory arrangements, including the number of surgeons in the unit.

In the past the transparency of the process has been criticised but the situation now may be different, as the increased number of advanced trainees has led to a concomitant increase in accreditation of posts. The Team cannot make definitive comments about the nature of any change in the absence of any data or formal evaluation by the College.

The College guidelines on accreditation are broad, and there is no clear and explicit relationship that indicates that there is a threshold level of number of procedures or types of procedures below which a position will not be accredited, or above which a position is likely to be accredited.

The accreditation decision is an important one for the College, trainees and hospitals. Given the ‘apprenticeship’ model that underpins advanced training, the decision to accredit a post or unit is fundamental and it therefore warrants clear objectives, guidelines and criteria. Accreditation reports should contain standardised information about training experience to inform the College/specialty

society decision. This information should encompass facilities, the nature of the trainee experience and the work of the unit, including its quality management processes. The accreditation visit should gather information from a range of stakeholders, including, of course, trainees. The decision to accredit can also be used by the College to shape the training environment for its trainees by encouraging hospitals to change. The survey of surgical supervisors conducted as part of the AMC accreditation process revealed considerable dissatisfaction with the College's encouragement of training institutions and hospitals to provide/upgrade educational resources/equipment (43 out of 93 respondents proposing improvements).

The accreditation process appears to focus on the documentation provided by the hospital and the relevant surgical unit. Informal feedback from trainees as part of this AMC accreditation process suggests that in a number of instances the interest of trainees seems to have been de-emphasised as part of the College process. Trainees suggested that the accreditation process should also take into account broader issues about the training environment. In particular, the need to ensure that the hospital meets commitments about trainee participation in mortality and morbidity reviews.

The changing expectations of both trainees and specialists about safe working hours is a critically important issue, affecting all parts of the medical profession. The College should ensure that its trainees function within reasonable rostered hours and that hospitals not place unreasonable obligations on trainees. Unreasonable hospital expectations of work hours mean that training opportunities described in hospital documentation may effectively not be available to trainees because of the need to meet service commitments.

The College also needs to ensure that trainees have adequate time available for education, reflection, research projects etc. Similarly, as the College moves more towards a Web-based provision of educational programs, the College needs to ensure that hospitals seeking accreditation or being re-accredited provide adequate access to computers, and protected time for trainees to use them.

Health sector policy is changing rapidly and some changes could be disadvantageous for training. It is clearly in the long-term interest of the health sector to ensure an appropriately qualified future workforce but this may conflict with short-term budgetary imperatives. The College can influence decision-making towards a greater emphasis on longer term issues. The way in which hospitals respond to budget pressures may vary from hospital to hospital and so educational aspirations may not conflict with service needs to the same extent at every hospital. The College should be using its influence on hospitals as part of its accreditation process to ensure that longer-term issues are given due consideration. The College would be able to be more effective in influencing hospital decisions if

it maintained a database that compares the response of different hospitals to the same environmental pressures.

The College itself has been under pressure from external bodies (such as State health departments and the Australian Competition and Consumer Commission) to demonstrate that it is not unreasonably restricting access to training. The College would be in a stronger position to respond to these pressures if it demonstrated its concern for addressing some of the longer term needs of providing a suitable training environment (including addressing issues such as the reduction in outpatient activity). The College does not appear to have a clear strategy for attempting to address the effect of these system-wide issues on opportunities for training. Although the College has attempted to lobby State and Federal governments in the past, the AMC Accreditation Team was not provided with documented evidence of effective proposals to address some of these issues.

The nature and location of patient care are changing. More patients are attending private hospitals and the Team encourages the College to expand training in private hospitals.

Recommendations

1. *That the College develop a clear statement of objectives of accreditation of posts/units;*

2. *That the College develop a clear statement of criteria for accreditation;*

3. *That the College incorporate information about the quality of trainees' experience (including documentation of clinical experience in logs and the nature of service requirements) in re-accreditation decisions, and explicitly seeks feedback from trainees themselves as part of this process;*

4. *That the College should ensure that accreditation teams explicitly review and comment in their reports on processes within units for quality management and peer review;*

5. *That the College should continue to consider a wide range of training posts such as private hospital training and training outside hospitals.*

7 SUPERVISORS, ASSESSORS, TRAINERS, MENTORS

The interaction between trainers and trainees is fundamental to surgical training. The Team was impressed by the commitment of trainers to their trainees and to the educational programs at their hospitals. Most trainers felt their fellow consultants were equally dedicated to the residents and registrars. Those who attended the Surgeons as Educators or Training the Trainers courses felt these were helpful in furthering their teaching skills and managing their educational programs. Most felt additional programs need to be made available to help guide their efforts. Supervisors did not feel the materials currently sent to new supervisors were sufficient for helping a new supervisor begin their responsibilities. Supervisors seemed to sincerely enjoy their role, were reasonably pleased with the quality of their programs, but voiced appreciation for additional assistance in furthering their programs.

There was some variability in supervisors' perceptions of their responsibilities and their abilities to effect or control the quality of education within their hospitals. Not all supervisors felt they had sufficient input to RACS program policies and procedures. Some noted the need for additional support form the RACS for questions, vitality, and a sense of a 'community of supervisors'.

In hospitals accredited for Basic Surgical Training, a hospital supervisor is elected by the Specialty Supervisors, and formally appointed by the Board of Basic Surgical Training. The College accreditation submission indicates that the hospital supervisor is responsible for coordinating the local Basic Surgical Training Program, for advising BST trainees and for ensuring the completion of in-training assessment reports.

In Advanced Surgical Training, supervisors of training are recommended by the appropriate Specialty Board on the nomination of the hospital, with formal approval of the appointment by the Censor-in-Chief's Committee and Council. The duties of specialty supervisors are defined in the *Guide to Surgical Training 1996.* These indicate wide-ranging responsibilities including:

1. advising Advanced Surgical Trainees on all aspects of surgical training;

2. ensuring that Advanced Surgical Trainees are appropriately registered;

3. monitoring logbook entries by regular inspection;

4. arranging regular meetings with surgeons to discuss programs and progress of individual trainees;

5. providing confidential reports to the Specialty Board's Regional Subcommittee to enable recommendations regarding eligibility to sit the Part 2 examination and progress and completeness of training;

6. membership of the Regional Subcommittee of the Specialty Board;

7. participating in the College's inspection of their specialty program at the hospital;

8. participating in the selection of Advanced Surgical Trainees.

Recommendations

That the College develop:

- *A formal description of supervisor and teaching staff qualifications and responsibilities. For example, required qualifications for the Supervisor may include: satisfactory and documented clinical, educational, and administrative abilities and experience; appointment in good standing to the medical staff of the hospital participating in the program; appointment normally for at least the length of the program plus one year.*

- *A formal description of the responsibilities of the director of the Training Program.*

COURSES FOR SUPERVISORS AND FELLOWS

The RACS has recently developed its 'Surgical Teachers' course. This course is designed for supervisors who are supervising and mentoring surgical trainees in Australia and New Zealand and will be widely available to surgeons who deal with trainees. The course is residential and extends over two and a half days. The four central content areas are adult learning, teaching skills, feedback and assessment, effecting change. The initial course (Surgeons as Educators) was delivered by instructors from the American College of Surgeons after adaptation for local needs. Participants in that course will act as instructors for subsequent courses.

Supervisors need a formal orientation and introduction to their responsibilities. All supervisors deserve courses and information that can help them to be more effective in their roles. Therefore, two courses are recommended. One course would be for new supervisors, perhaps held annually depending on the number of new supervisors. A second course could be available for existing supervisors, and if possible other trainers, aimed at enhancing their teaching, assessment, and educational administrative skills.

All trainers should be required to attend a workshop on giving performance feedback and providing meaningful performance information on assessment forms.

The supervisor's task of determining appropriate rotations or jobs for each trainees would be assisted by a curriculum document that outlines, in terms of learning objectives, what trainees should know and be able to do at the end of each year of training. The supervisor's role should include informing other trainers in their program of these learning objectives.

FEEDBACK TO SUPERVISORS AND TRAINERS

Supervisors and trainers require feedback on their performance as program administrators and trainers to better understand their strengths and weaknesses. Trainees should have the opportunity to evaluate all surgeons involved in their training. This could be undertaken annually to protect the anonymity of the trainees. The data should be summarised in a report that helps trainees and supervisors constructively compare their skills as teachers/managers to those of others. Trainees should also evaluate their jobs and work environment, again to help inform the supervisor and trainers so they can preserve those aspects of the program that worked well, and address program weaknesses as needed. Support for poorly rated supervisors should be offered, and any supervisors receiving continued negative ratings should be replaced.

MENTORS

Some AST Programs have formal mentor systems, with trainees assigned a mentor at the beginning of their training. This was generally strongly supported by trainees, although there was potential confusion between the role of mentor and supervisor, especially when this was the same person. Discussions with trainees indicated that implementation of mentor programs was patchy. The Team considers that the role of mentor should be separate from that of supervisor, and suggests that the College consider a clearer definition of its policies.

COMMUNICATION

The College would benefit from a system that allows effective communication to and from RACS, its supervisors and trainers. For such a dispersed group, enhancement of the RACS website would be preferable to additional written documents. The Team was told by trainees and supervisors that these were not well coordinated in the College. The College might consider including on the Web page a section for supervisors, that is updated at least monthly so that supervisors can check once a month for new information. Each supervisor should have an email address for more urgent messages, 'newsflashes' and timely communication initiated by the supervisor. A second communication system, also using the Web page could be a 'Thumbnail sketch' bulletin for all supervisors and trainers, again updated monthly (and at the same time each month). This could include brief teaching tips, supervisors sharing best practice, or a summary of significant questions posed monthly by supervisors and trainers. As is the case for all Web pages, RACS can improve the effectiveness of its site as a communication tool by ensuring that there is a designated person responsible for updating and ensuring accuracy and the timeliness of responses, and by providing appropriate hardware support.

TRAINER MOTIVATION AND RECOGNITION

Although many trainers and supervisors demonstrated considerable enthusiasm for their programs, the roles of individuals and of posts should be reinforced and recognised for their excellent contributions. An award system for acknowledging exemplary programs and teachers should be developed to demonstrate that commitment to excellence and effort and outcomes are valued.

8 MONITORING AND EVALUATION

Supervisors, hospital administrators, and consultants stated clearly to the Team that they welcome evaluative feedback to help monitor quality control and to identify areas of strengths and areas needing attention. Some felt that this type of program evaluation data would enable them to enhance their programs and better understand components of the program that are not working.

Many of the educational initiatives implemented by the RACS are still in the developmental stages or relatively new, and as a result, program evaluation systems have not yet been planned. Recommendations on building such systems follow.

RECOMMENDATIONS FOR PROGRAM EVALUATION

Evaluation can occur at several levels.

- **Implementation evaluation** assesses associated costs, resources used, and any discrepancies between planned and actual implementation.

- **Reaction evaluation** assesses how stakeholders (or those individual affected by the program or initiative) feel about or perceive the program or initiative. This is typically done through a form completed at the end of the program that asks trainees to rate for example, 'the value of the topic presented' and 'the quality of the presentation'.

- **Evaluation of learning** assesses the extent to which trainees gained proficiency in the established learning objectives. This is typically accomplished through testing or self-assessment.

- **Outcome evaluation** studies the influence of the program or initiative. For example, if evaluating an independent learning module on the topic of nutrition, the evaluation of learning would possibly include the results of an examination. Impact or outcome evaluation might look at whether trainees altered how they monitored their patients' nutritional needs possibly comparing charts before and after module completion.

Because both the RACS and the individual hospitals share responsibility for educating trainees, programs require evaluation at both levels.

An educational program is comprised of multiple components. Evaluation data regarding the various components can be acquired from trainees, trainers, supervisors, ancillary health professionals, and patients, depending on the scope of evaluation desired. Important components of the educational program that require assessment include:

- the learning environment;
- the intellectual environment;
- quality and frequency of performance feedback;
- appropriateness of caseload and mix;
- appropriateness of supervision;
- appropriateness of clinical experiences to specified learning objectives by resident/registrar level;
- commitment and availability of consultants;
- commitment and availability of supervisor;
- quality and availability of educational conferences (case discussions, etc.);
- overall global evaluation of program.

This list is not exhaustive, but includes some of the major components. To ensure clear understanding and consistency of ratings, it is critical that each of these components is defined for the rater.

Methods for collecting evaluation data vary. Some options include:

- standardised evaluation forms for evaluating jobs, consultants, hospitals, specific programs, etc;
- longitudinal follow-up forms for assessing graduate outcomes one year post graduation, in which graduates might rate the frequency of performing a listed procedure during their first year in practice, and whether or not they felt they had received too much, too little, or sufficient instruction/experience during their training;
- systematic review of case logs;
- document reviews (chart reviews);
- focus group discussions;

- tests or examinations (written, oral, or performance based);
- summarised performance assessments;
- direct observation;
- portfolio reviews.

Regardless of the method(s) chosen, it is critical that every form of evaluation be developed as a *system*. This requires the documenting of the purpose and procedures for conducting the evaluation outlining why the data is being collected, from whom, when, how and how frequently the data will be analysed, who will receive the summary reports, and what decisions or actions might be taken based on possible findings. Indications of how and when poor results will be followed up are also part of the evaluation system plan. Without a systemised evaluation system, the evaluation data will not meet its full intentions. Mark Twain is credited with saying 'Collecting evaluation data is a lot like collecting garbage. You better know what you are going to do with it before you collect it!' This suggests that unused evaluation data is not worth taking the time or trouble to collect. It is recommended that the College involve a person expert in evaluation system development when planning these systems.

The adoption of an evaluation information management system would conserve resources. An electronic system can greatly reduce the oversight needed to implement the systems and resolves issues of printing, mailing, data entry, report writing, etc. An appropriate Web-based system can enable access anywhere in the country, and can expedite the many steps outlined above related to an evaluation system from data collection to report generation and follow-up.

DATABASES FOR MONITORING PROGRAMS

An electronic database should be developed to list trainees as they enter the surgical education system, and track them as they progress to completion of the program. This is critical to monitoring trainee progress, and ensuring that every trainee's status is clearly known to the RACS. Aggregate data provides important information about the surgical education programs.

Other databases for monitoring the educational programs may be worth considering, for example, caseloads and mix by hospital/state.

SUMMARY

The Team recognises that not every aspect of every educational program can be evaluated. If adequate program evaluation is not pursued however, there must be concerns that quality control measures are not being exercised. The RACS needs to set priorities concerning the aspects of its educational programs for which it requires program evaluation feedback, and needs to ensure proper evaluation systems are fully developed and functional. This should include establishing 'red flag' criteria when evaluation systems are planned and documented, that is identifying in advance the data that would indicate significant problems together with proposed consequences. Some evaluation systems may require a pilot study before full implementation. At reasonable intervals, all evaluation systems should be studied for continued evidence of reliability, validity, and feasibility.

Representatives of all stakeholders should be involved in the development of the system. In addition, all the stakeholders should be informed of the system so they fully understand what is being evaluated and how the College intend to use the data.

9 CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

In its review of the College's Continuing Professional Development (CPD) program, the Team drew information from the following sources:

- a focus group session with the Board of Continuing Professional Development;
- Department of Continuing Professional Development Program Information Manual 2001;
- the College's Accreditation Submission of May 2001;
- an AMC/CPMC issues paper of April 2001 on a national approach to the registration of medical practitioners;
- the Medical Council of New Zealand's policy on recertification, April 2000.

Regulatory reform of medical registration, as it is developing in Australia and New Zealand, provides an essential background to this review of the RACS CPD program. The AMC/CPMC issues paper outlines plans for three related initiatives leading to:

- a system of national portability of medical registration;
- a system of specialist registration, with categories of practice linked to appropriate qualifications;
- the linking of continuing certification of professional competence to registration.

The policy on recertification developed by the New Zealand Medical Council requires that, from 1 July 2001, all medical practitioners need to be enrolled in a CPD program in order to maintain registration.

In the light of these initiatives and requirements, the Team sought to clarify the College’s position on the link between its CPD program and continuing certification. To gain this information, the Team examined the role and purpose of CPD as presented in the review documentation and asked members of the Board to articulate their views.

ROLE AND PURPOSE OF THE CPD PROGRAM

The Continuing Professional Development Program Information Manual 2001 states that the role and purpose of the Program is to:

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

This statement, affirmed in comments by the Board, indicates that individuals are encouraged to participate in a professional development program designed to meet the day-to-day activities of surgeons. During interviews it was mentioned a number of times that CPD is considered to be a compulsory activity for all Fellows; but this is not made explicit in any documentation. There is no reference to time-limited certification; the certificate awarded on completion of a three-year cycle of CPD activities is not essential for a Fellow to continue certification.

Currently, 95 per cent of Fellows of the College participate in the CPD program. For these Fellows the pathway is clear; their certification to practise as surgeons is continuing and, according to the AMC/CPMC initiatives and NZMC requirements, specialist registration is maintained.

The College is not clear about its intentions regarding the five per cent of the Fellowship who do not participate in CPD. According to the Manual, 'Fellows…experiencing difficulty meeting any of the requirements of the Program' are to be counselled by their specialty society, with the provision of, ultimately, a declaration of a Fellow as 'non-participant'. The Submission refers to this final measure as 'a forwarding of names to its Council 'for further consideration'. There are no details to show how these processes are implemented, or if a penalty is incurred.

In the Team's interview with the Board, there was considerable difference of opinion among members as to what measures should follow non-participation and who should enforce such measures. Although the Manual affirms the concept of self-regulation, some Board members were reluctant to accept regulatory measures as a responsibility of the College. There was also a suggestion that regulatory measures may not be legally enforceable.

In the interests of public accountability, a situation where non-participatory status is not dealt with, and communicated only on request, does not give convincing evidence of self-regulation. The Team notes from the Submission that the Board of Continuing Professional Development is 'considering stronger options to ensure that all eligible Fellows participate' and urges the Board to develop appropriate strategies for addressing this matter.

Recommendations

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

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

STRUCTURE OF THE CONTINUING PROFESSIONAL DEVELOPMENT PROGRAM

The College has made significant progress in developing a structured and practical CPD program. Program requirements are structured according to the types of surgical practice engaged in by Fellows, notably those who carry out operative procedures, with alternative requirements for Fellows who engage in non-procedural or other work practices. The program cycle spans three years. Minimum requirements, in terms of the hours of activity undertaken, are listed for each type. A randomly selected 2.5 per cent Verification Project will be conducted annually from 2001 onwards.

CPD activities are organised in categories. Information for each category includes the activities required plus the compliance and verification requirements. A thoughtful range of professional activities is offered, with an appropriate degree of flexibility built in. The information presented in a clear and straightforward manner. Details of the categories are given in the following table:

Category	**Activities**	**Compliance requirement**
One	Surgical audit, peer review, hospital credentialling	Annual audit; approved project; peer review of audit; evidence of being credentialled to a hospital every three years
Two	Clinical governance	45 hours over three years
Three	Maintenance of clinical	Attendance at RACS or Specialist Society

	knowledge and skills	scientific meetings; approved courses; peer review
Four	Teaching activities	Teaching and preparation; examination involvement
Five	Research and publication activities	Participation in ASERNIP-S review; research; clinical trials and research; scientific publications and presentations
Six	Continuing professional development activities	Participation in RACS non-clinical courses; participation in approved courses; involvement in approved volunteer services

Audit plays a central role in the CPD of practising surgeons. This is a sound educational development, providing an excellent basis for follow-up practice improvement activities. The Team also acknowledges the attention that the College pays to rural and isolated practitioners. Special programs and means of professional support are provided for this group.

FUNCTIONING AND IMPLEMENTATION OF THE CPD PROGRAM

In the course of its one interview with the Board, the Team could not examine details of how the CPD program is being implemented. The College has invited the specialist societies to take a role in encouraging and monitoring the CPD activities of society members, and the Manual includes positive responses from several of these societies. Details of how the societies implement the CPD program of the College and assess the progress of their members were not made available to the AMC Team.

The College's submission does provide an example of how a College professional development activity is implemented. This attachment gives information on the RACS Surgical Teachers Course, a course based on a 'Surgeons as Educators' developed by the American College of Surgeons. The ways in which the course is implemented are clear from the course outline: content and learning objectives are articulated; learning methods are hands-on, varied and centred on the day-to-day teaching that surgeons do; and the course is routinely evaluated. This course outline provides an excellent model for the design of CPD activities. Importantly, it communicates clearly to Fellows what and how they can expect to learn when they register for it.

EVALUATION OF THE CPD PROGRAM

Questions posed to Board members regarding the evaluation of the CPD program revealed that no evaluation of any aspect of the CPD program has been undertaken at this stage. The Team urges the Board to formulate strategies for, at least, evaluation of its CPD activities; for it is through such evaluation that new areas for learning and professional development will be identified. The literature on educational evaluation shows that evaluative activities can be used productively as means for improvement, and advises that such activities should be fundamental (not optional add-ons) to educational programs.

ADDRESSING THE PRACTICE OF UNDER-PERFORMING SURGEONS

Increasing public awareness and knowledge about medical practices is putting the spotlight on under-performing doctors. The role of medical colleges in identifying and addressing the practice of Fellows who are under-performing in areas of their specialty is currently ill defined. The College has not at this stage developed plans for dealing with this most difficult of problems systematically and with transparency; and there is no indication that other medical colleges have progressed any further. The privilege of self-regulation demands that medical colleges will need to address this challenge as a matter of priority. The Team considers that educational principles should take a pivotal place in the development of positive and productive strategies to address this important need.

RETRAINING OF SPECIALISTS

It is intended that the RACS Board of Continuing Professional Development (CPD) would identify the deficiencies and construct an appropriate training program for Fellows whose performance has been found to be unsatisfactory. The Department of CPD would take responsibility for monitoring the progress and competence of the Fellow.

The program of CPD is still in its infancy and so far the program has identified no Fellows as in need of retraining. There does not appear to be any official program in place to allow retraining of a specialist identified as an under performer by a medical board, but presumably such a Fellow would be encouraged to participate in programs organised by the Department of CPD.

Recommendation

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

10 CONCLUSIONS

INTRODUCTION

The Team wishes to express its gratitude for the courteous and constructive manner in which the College, its Office Bearers, Fellowship, trainees and College staff, treated it. The review was done at a time of great transition within the College and in an external environment that is also changing. The Team believes that the process was collegial and trusts that the College will find support for many of the changes that it is introducing.

The Royal Australasian College of Surgeons delivers a training program through its Fellowship. The Fellows do this voluntarily. This is a great strength but also poses great challenges not only to this but to all similar colleges. Standards of training, especially in technical areas are very high. There are however matters of concern to the Team which are presented in a sequence that follows the structure of the report. Less important matters are not reviewed in this section but should be considered in context by the College. Many of the problems are not unique to the Royal Australasian College of Surgeons and are being dealt with by the College.

EDUCATION AND TRAINING PROGRAMS

The Basic Surgical Training program has recently been radically changed from a period of unorganized self-directed learning to a structured educational program. The Team commends the College for this. Advanced Training is carried out in nine areas, several of which are controlled by Special Societies affiliated with the College. While interaction with several of the special societies appears to be constructive the Team believes that it is important that all Special Societies with responsibilities for selection, education and assessment follow RACS guidelines. The Team recommends development of Heads of Agreement/Memoranda of Understanding with the Special Societies covering all aspects of selection, training and assessment.

The College has done some admirable work on its educational programs but these would benefit from further development, with better documentation of the learning objectives and development of syllabi. Syllabus development will be a major task for the College but will significantly enhance the training programs. Systems for program monitoring and evaluation, including feedback from trainees and supervisors, should be incorporated into the design of programs. The psychometric aspects of summative assessment would benefit from skilled external review. The Team was impressed by the

efforts made to ensure that trainees achieved technical proficiency. It is however important that the non-technical aspects of surgical practice, as set out in the CanMEDs document, are also made an integral part of surgical training.

There would be major benefits if information for trainees and supervisors were better organised and distributed in a streamlined and coordinated way. This could, with benefit, be via the Web.

TRAINEES

Although the College has made great advances in processes for selecting Basic and Advanced Surgical trainees selection remains an important issue. The Team believes that trainees would benefit from being allowed to delay their selection into Basic Surgical Training until PGY 3. Parts of their PGY2 experience could be retrospectively accredited without, the Team believes, adversely affecting the educational experience of Basic Training.

The selection process in several training areas does not conform to Brennan principles. The Team recommends that within the next 12 months all selection procedures satisfy these principles.

There are large numbers of trainees waiting to enter Advanced Surgical Training. The College understands the magnitude of this problem and the Team commends moves to change selection processes to ensure a 'seamless' transition from Basic to Advanced Surgical Training.

The issue of 'non-accredited training posts' remains a big concern for trainees. Some, at least, of these posts appear suitable for training purposes and again the Team commends the College for its intention to recognise for training all suitable positions. The Team believes that service in 'non-accredited' posts should not be a part of the College training program.

The College has begun to consider methods of representation of trainees in College affairs. The Team endorses this and recommends that trainee representation be instituted throughout the College.

The proportion of female medical graduates is rapidly rising. Adequate mentoring programs should be established to help female trainees.

ASSESSMENT AND EVALUATION

Trainees need performance feedback and mechanisms for improving the formative assessment of Basic and Advanced Surgical Trainees should be established.

The importance of teaching and assessing non-technical aspects of surgical training has been mentioned above, as has the need for external evaluation of psychometric aspects of summative assessment.

ENVIRONMENT FOR TRAINING AND TEACHING

Changes in hospitals and health care financing are affecting all Colleges. The loss of outpatient departments from teaching hospitals is depriving many trainees of important experience in preoperative assessment of patients with surgical disorders. While this to some extent can be remedied by working in private clinics the Team believes that all Colleges need to influence return of teaching outpatient clinics to teaching hospitals.

Many large hospitals are carrying out only major surgical operations so that many trainees are gaining less experience in routine surgery. The Team commends the College's moves to increase exposure to this type of surgery in private hospitals.

These changes in the educational environment mean that the College must ensure adequacy of training. Accreditation of training institutions is a powerful tool for this. Criteria for accreditation should be detailed and better documented. Trainees' views of training hospitals should be used in the accreditation process.

The apprenticeship mode of surgical training means that better training of supervisors/mentors/trainers, especially in delivery of constructive comments about progress in training is important. Better communication to and from trainees/supervisors/mentors/trainers should also be encouraged.

OVERSEAS TRAINED SURGEONS

The College is asked to assess many surgeons trained in countries other than Australia and New Zealand. It is essential that this process is timely and the College should consider the development of

innovative assessment processes. The requirement for all overseas-trained surgeons to spend time in hospital assessment should be reevaluated.

CONTINUING PROFESSIONAL DEVELOPMENT

The College's continuing professional development program has been in place for some time and is typical of medical college programs in this country. It would benefit from internal evaluation. The issues of making the program compulsory and what to do with non-performers should be considered.

THE TEAM'S DRAFT RECOMMENDATIONS

This review was conducted as part of a pilot program, designed to test the draft Guidelines and process of accreditation. Whilst the draft Guidelines for Accreditation contain suggested options for the AMC Council's decision on accreditation, these are still under consideration, and were not discussed by the Team.

Before the pilot commenced, the AMC Council considered whether the reviews of the Royal Australasian College of Surgeons and the Royal Australian and New Zealand College of Radiologists should lead to recommendations concerning accreditation. Consistent with the decisions taken when medical school accreditation began, the Council envisaged that it would grant transitional accreditation to all the currently recognised specialist education and training organisations when it implements the process of accreditation of specialist medical training. Each organisation would retain its transitional accreditation until the AMC reviewed its training and professional development programs. In view of the number of training providers, some may have transitional accreditation for up to six years.

The AMC Council therefore agreed that, when the accreditation process is formally established, the two participating Colleges should be given accreditation for the maximum period allowable with or without conditions. Anything less is likely to be a shorter period than the transitional accreditation granted to other Colleges.

In the light of this decision, the Team proposes the following draft recommendations on accreditation, for consideration when the accreditation process is formally established.

The Team recommends full accreditation of the Royal Australasian College of Surgeons, with the requirements of an annual report from the College to the AMC addressing the Team's recommendations, and in particular:

a. Development of a Heads of Agreement/Memoranda of Understanding with the Special Societies covering all aspects of selection, training and assessment.

b. The further development and specification of the College's educational programs

c. Integration of the non-technical aspects of surgical practice, such as those set out in the CanMEDS document, in training and assessment.

d. Development of systems for program monitoring and evaluation.

e. Requirements for selection consistent with the Medical Training and Review Panel Report (the Brennan Principles).

f. Further attention to the issues relating to 'non-accredited training posts'.

g. Improved mechanisms for formative assessment of trainees.

h. Review of the criteria and processes for accreditation of training post and institutions.

i. Review of the strategies and mechanisms for communication to and from the College, trainees, supervisors, mentors and trainers.

j. Further attention to the issues relating to assessment of overseas trained surgeons.

The Team suggests that a further review should be undertaken if the College does not demonstrate appropriate development in these areas over a three-year period.

CONTENTS

- **1 ..... INTRODUCTION 1**

Review of Specialist Medical Education and Training Programs 1

The Review Process 2

Review of the Royal Australasian College of Surgeons 4

Appreciation 5

This Report 5

Notes on terminology 6

- **2 ..... THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS 7**

Description 7

Structure 8

Strategic Issues of Current Importance to the College 9

- **3SPECIALIST MEDICAL EDUCATION AND TRAINING PROGRAMS 11**

Overview 11

Basic Surgical Training (BST) 12

Advanced Surgical Training (AST) 15

Structure 16
Syllabus and Advanced Surgical Training content 17
Transition from Basic Surgical Training 18
The training environment 19
The training experience and assessment 20
Advanced Surgical Training in Cardiothoracic Surgery 21
Advanced Surgical Training in General Surgery 22
Advanced Surgical Training in Neurosurgery 24
Advanced Surgical Training in Orthopaedic Surgery 25
Advanced Surgical Training in Otolaryngology - Head and Neck Surgery 26
Advanced Surgical Training in Paediatric Surgery 27
Advanced Surgical Training in Plastic and Reconstructive Surgery 28
Advanced Surgical Training in Urology 29
Advanced Surgical Training in Vascular Surgery 30

Educational Programs 31

Learning aids 32

Research in Training 33

- **4 ..... ISSUES RELATING TO TRAINEES 35**

Selection of Trainees 35

Trainees with Intermediate Status 39

Could experience in non-accredited jobs be credited for training? 39
The numbers of trainees involved 40
The trainees' relationship with the College 41
Selection of posts and experience 41

Trainee Representation in College Affairs 42

Women in Surgery **43**

- **5** ..... **ASSESSMENT AND EXAMINATION** **46**

Assessment in Basic Surgical Training **46**

Formative assessment or performance feedback ***46***

Summative assessment ***48***

Trainee guides to assessment ***49***

Procedures concerning unsatisfactory performance ***50***

Assessment and Examination in Advanced Surgical Training **50**

Assessment of Overseas-trained Surgeons **52**

- **6** ..... **ENVIRONMENT FOR TRAINING AND TEACHING** **56**

College Accreditation of Hospitals and Training Positions **56**

- **7** ..... **SUPERVISORS, ASSESSORS, TRAINERS, MENTORS** **59**

Courses for Supervisors and Fellows **60**

Feedback to Supervisors and Trainers **61**

Mentors **61**

Communication **62**

Trainer Motivation and Recognition **62**

- **8** ..... **MONITORING AND EVALUATION** **63**

Recommendations for Program Evaluation **63**

Databases for monitoring Programs **65**

Summary **66**

- **9** ..... **CONTINUING PROFESSIONAL DEVELOPMENT (CPD)** **67**

Role and Purpose of the CPD Program **68**

Structure of the Continuing Professional Development Program **69**

Functioning and Implementation of the CPD Program **70**

Evaluation of the CPD Program **71**

Addressing the Practice of Under-Performing Surgeons **71**

Retraining of Specialists **71**

- **10** ..... **CONCLUSIONS** **73**

Introduction **73**

Education and Training Programs **73**

Trainees **74**

Assessment and Evaluation **75**

Environment for Training and Teaching **75**

Overseas Trained Surgeons **75**

Continuing Professional Development **76**

The Team's Draft Recommendations **76**

APPENDICES

Appendix 1	Executive Summary Draft Guidelines for the Accreditation of medical Specialist Education and Training and Professional Development Programs
Appendix 2	Membership of the RACS Accreditation Team
Appendix 3	Visit programs for the RACS Accreditation Team
Appendix 4	Definitions

DRAFT GUIDELINES FOR THE ACCREDITATION OF MEDICAL SPECIALIST EDUCATION AND TRAINING AND PROFESSIONAL DEVELOPMENT PROGRAMS

EXECUTIVE SUMMARY

Part 1 deals with the background to the development of the draft accreditation guidelines and the aims of accreditation. It:

- Reviews the role of the Australian Medical Council.
- Describes the perceived advantages of accreditation as a quality assurance mechanism.
- Includes a statement of aims of the accreditation process. The aims are:

1. To assess if the education, training and professional development programs of the College being accredited:
   - are relevant to the objectives and outcomes determined by the College,
   - are appropriate in terms of modern educational methods and clinical practice,
   - include appropriate assessment methods that test the trainee's knowledge, clinical skills, attitudes and expertise for safe and competent practice of the specialty.
2. To encourage further improvements and developments in the program being accredited to enhance its educational quality.
3. To provide an opportunity for the organisation being accredited to review and assess its program.
4. To assure the community that a doctor who has successfully completed an accredited specialist education and training program is able to practise as a specialist in that area and is being assisted to maintain and enhance her/his knowledge, competence and performance.
5. To provide the basis for granting registration to practise in the relevant specialty.
6. To focus on the achievement of objectives, maintenance of academic standards, public safety expectations, and good outputs and outcomes rather than on detailed specification of curriculum content relevant to the specialty or discipline.

- Proposes four broad goals of specialist education and professional development:

1. Specialist education and training is to enable the trainee to gain an understanding of the scientific basis of the discipline and to learn through exposure to a broad range of clinical experience in the relevant specialty.
2. On completion of training, a practitioner is able to undertake unsupervised comprehensive medical practice in the relevant specialty (including general practice).
3. The training should include a process of assessment that tests whether the trainee has acquired the requisite knowledge, skills and attitudes to practise in the specialty at an appropriate standard.
4. Trained specialists (including general practitioners) must be prepared to assess and maintain their own competency and performance through continuing professional education, maintenance of skills and the development of new skills.

- Describes the broad responsibilities of the medical specialist in the health care of the community, building on the work of the Royal College of Physicians and Surgeons of Canada *CanMEDS 2000 Project.* These describe roles of medical expert, communicator, collaborator, manager, health advocate, scholar, and professional.

Part 2 comprises the draft recommendations on the processes of specialist education and training and professional development. These cover the elements regarded by the AMC Consultative Committee as key attributes of successful specialist education and training and professional development programs. Recommendations are followed by questions that are intended as a guide to the material that would be required by an accreditation team. The recommendations cover:

- Processes for defining the goals of specialist education and training.
- Structure and design of the training program.
- Advanced training in subspecialty areas
- The generic and discipline-specific components of training
- Issues relating to the environment in which specialist medical training occurs, including:
  - The relationships with the training institutions/hospitals.
  - Conflicting demands between health service delivery and education and training.
  - Funding teaching hospitals to allow for the additional costs of providing educational experience.
  - Structured educational programs, and facilities and educational resources.
- Issues relating to the training organisation's processes and criteria for accreditation of hospitals/training positions and mechanisms for monitoring the compliance of training sites with these policies.
- Issues relating to supervision of trainees. Definitions and roles of supervisors, assessors, trainers and mentors are suggested, but it is recognised that training organisations devise and implement structures in response to their particular goals and challenges.
- Issues relating to processes of selection of trainees and appeals by trainees. The principles of the 1998 Medical Training Review Panel report "*Selection into Specialist Training Programs*" are endorsed.
- Issues relating to assessment and examination including:
  - Matching goals and objectives to formative and summative trainee assessment.
  - Requirements for explicit assessment criteria and for clear procedures for dealing with unsatisfactory performance and disputes over supervision and assessment.
- Procedures and criteria for assessment of overseas trained specialists. It is recognised that this assessment activity is an important service for the Australian community in ensuring that the standards of its medical services are maintained.
- Outputs and outcomes of training.
- Monitoring and evaluating of training programs.

Part 3 deals with processes for determining and monitoring professional development programs. It describes these activities as an important component of self-regulation by the medical profession, which therefore need to be incorporated into accreditation. Questions are included to assist training organisations to formalise their responses to issues concerning professional development activities. Questions are also asked about the training organisations' processes for evaluating its continuing professional development programs.

Part 4 is concerned with the proposed accreditation process. It:

- Sets out the proposed structure for administration of the accreditation process including the terms of reference of the AMC Specialist Education Accreditation Committee, and the role, training and membership of accreditation teams.
- Describes the potential contributions of trainees to the review and accreditation process.

- Describes the proposed processes for accreditation of an established specialist education and training programs, including the following steps:
    - Development of a self-study document by the training organisation.
    - Appointment by the AMC of an accreditation team, after discussion with the training organisation being accredited.
    - Development of a program for the accreditation involving review of documents, meetings and site visits.
    - Preparation of a detailed accreditation report, with opportunities for the training organisation to comment on the draft report.
    - A process for a training organisation to seek a review of the draft accreditation report and/or accreditation recommendations.
- Outlines the processes that would be invoked if an accredited training organisation proposed major changes to their training program or creates new subspecialty training program.
- Proposes regular periodic reports from the training organisation during the period of accreditation to enable the Australian Medical Council to monitor developments in the accredited training program.

Part 5 will deal with the process for considering the education and training programs of new medical specialties. A separate AMC working party is developing a model for the recognition of new specialties that provides for a process of external evaluation and formal recognition of new medical specialties and sub-specialties with significant resource implications for the health care system.

Part 6 sets out the proposed accreditation outcomes.

- Suggests the following accreditation decisions:
    - Accreditation for a maximum period subject to satisfactory reports from the training organisation during the period of accreditation.
    - Accreditation for a maximum period subject to certain conditions being addressed within a specified period and to satisfactory periodic reports.
    - Accreditation for shorter periods of time with conditions where significant deficiencies are identified.
    - Accreditation to be refused, recognising that the impact on the health care system and on individuals of withdrawal of accreditation would be such that accreditation should only be refused when every other avenue for correcting deficiencies has been exhausted.
- Outlines the procedures that would be invoked where the AMC identifies serious ongoing deficiencies that raise concerns in relation to the continued accreditation of the training organisation.

Part 7 includes preliminary discussion on the costs associated with the accreditation.

MEMBERS OF THE ACCREDITATION TEAM

Dr Robin Mortimer MBBS *Qld* FRACP **(Team convenor)**
Deputy President, Royal Australasian College of Physicians
Director of Endocrinology,
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Professor Debra DaRosa PhD
Professor of Surgery and Vice Chair of Education
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Chief Executive,
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Dr Andrew Wilson MBBS *Melb*
Senior Cardiology Registrar and Research Fellow
St Vincent's Hospital, Melbourne

PROGRAMME OF VISITS
TRIAL ACCREDITATION OF THE
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Monday, 28 May - Friday, 1 June 2001

ITINERARY FOR ACCREDITATION VISIT
DR ELEANOR LONG, DR ANDREW WILSON, DR JEFF HAMDORF

MONDAY, 28 MAY 2001

BENDIGO BASE HOSPITAL

LUCAN ST, BENDIGO

9.30am	Meeting with the: Executive Director, Acute Health Services Director of Surgery Director of Nursing Services
10.00am	Meeting with Supervisors of Training (all specialties) and surgeons at the Bendigo Base Hospital *with morning tea*
10.30am	Meeting with Registrars-in-training Registrars (non-training) Basic Trainees Part 1 holders but not as yet on a training programme Any overseas trained surgeons who have been assessed via the College/ AMC pathway
11.30am	Meeting with representatives of allied health professions at the Bendigo Base Hospital who work closely with surgical trainees.
12.15 pm	Lunch
1.00pm	Departure drive to Goulburn Valley Health – Shepparton Division

Goulburn Valley Health – Shepparton Division

GRAHAM STREET, SHEPPARTON

2.00pm	Meeting with the: Director of Surgery Director of Medical Services Director of Nursing Services
2.30pm	Meeting with Supervisors of Training (all specialties) and surgeons at the Goulburn Valley Health – Shepparton Division
3.15pm	Meeting with Registrars-in-training Surgical registrars Orthopaedic registrars

4.15pm Departure drive to Melbourne

ITINERARY FOR ACCREDITATION VISIT OF
PROFESSOR STEPHEN DUCKETT AND PROFESSOR DEBRA DAROSA

MONDAY, 28 MAY 2001

BOX HILL HOSPITAL

NELSON ROAD, BOX HILL

The head of the Department of Surgery will meet the AMC Team in the Boardroom Annex of the Clive Ward Building located off Arnold Street [go through the big glass doors]

7.30am Meeting with:
Director of Surgery
Supervisors of Training (all specialties)
Surgeons
with breakfast

8.15am Meeting with Registrars-in-training
Registrars (non-training)
Basic Trainees
Part 1 holders but not as yet on a training programme
Overseas trained surgeons assessed via the College/ AMC pathway

9.00am Meeting with representatives of allied health professions at the Box Hill Hospital who work closely with surgical trainees.
[Director of ICU, Emergency Theatre and Anaesthesia]

9.30am Departure drive to Monash Medical Centre

Monash Medical Centre

246 Clayton Road, Clayton
All meetings will be held in the Surgical Seminar Room, Block E, Level 5, MMC, Clayton Campus

10.30am Meeting with the:
Director of Surgery
Not Available - Director of Medical Services
Did not respond - Director of Nursing Services

11.00am Meeting with Supervisors of Training (all specialties) and surgeons at the Monash Medical Centre

11.30am Meeting with Registrars-in-training

Registrars (non-training)
Basic Trainees
Part 1 holders but not as yet on a training programme
Any overseas trained surgeons who have been
assessed via the College/ AMC pathway

12.30pm Meeting with representatives of allied health professions at the Monash Medical

Centre who work closely with surgical trainees.

1.00pm Lunch

2.00pm Departure drive to Maroondah Hospital

Maroondah Hospital
Mt Dandenong Road, Ringwood East

3.00pm Meeting with the:
Director of Surgery
Director of Medical Services
Director of Nursing Services

3.30pm Meeting with Supervisors of Training (all specialties) and surgeons at the Maroondah Hospital
with afternoon tea

4.00pm Meeting with Registrars-in-training
Registrars (non-training)
Basic Trainees
Part 1 holders but not as yet on a training programme
Any overseas trained surgeons who have been assessed via the College/ AMC pathway

4.45pm Departure drive to Melbourne CBD

ITINERARY FOR ACCREDITATION VISIT OF
DR J HAMDORF, DR MICHAEL WALSH AND DR ANDREW WILSON

TUESDAY, 29 MAY 2001

Meeting with a representative of the Chairman of the Victorian Regional Sub-Committee, Board In General Surgery

To run from 8.00 - 9.00am in the Hailes Room at the College Headquarters, Spring Street, Melbourne. Light breakfast will be served.

Melbourne Private Hospital
Royal Parade, Parkville
Melbourne

Site Visit Cancelled.

Team to meet at the College of Surgeons - Hailes Room is available for the team members.

ITINERARY FOR ACCREDITATION VISIT OF
PROFESSOR DEBRA DAROSA, DR ELEANOR LONG AND PROFESSOR STEPHEN DUCKETT

TUESDAY, 29 MAY 2001

St Vincent's Hospital, Melbourne
Cnr Victoria Parade & Fitzroy Street
Fitzroy, Melbourne

9.30am	Meeting with the: Director of Surgery Director of Medical Services Director of Nursing Services
10.00am	Meeting with Supervisors of Training (all specialties) and surgeons at the St Vincent's Hospital Melbourne *with morning tea*
10.45am	Meeting with Registrars-in-training Registrars (non-training) Basic Trainees Part 1 holders but not as yet on a training programme Any overseas trained surgeons who have been assessed via the College/ AMC pathway
11.30am	Meeting with representatives of allied health professions at St Vincent's Hospital who work closely with surgical trainees.
12.00 noon	Departure

Tuesday, 29 May

All team

1.30 - 3.30pm	Meeting Saville Park Suites, 333 Exhibition Street
3.45 - 4.00 pm	Team invited to afternoon tea with Censor in Chief's Committee, Hailes Room first floor, College Headquarters, College of Surgeons Gardens,
4.00 - 6.30 pm	Meeting with Censor in Chief's Committee. Council Room, first floor

Team meeting to 8.00pm Saville Park Suites.

Wednesday, 30 May

8.30 - 10.30am Continuing Professional Development Committee: 4 members reps, including the Chair, from CPD. Council Room, first floor

10.30 - 10.45 am	Morning Tea. Council Room, first floor. Will include BST reps

10.45am - 12.30pm Board of Basic Surgical Training, five members. Council Room.

12.30 - 2.00pm Team meeting and lunch. Saville Park Suites.

5.30 - 7.00pm Team Meeting With Advanced And Basic Surgical Trainees. Council Room, College Headquarters, College Of Surgeons' Gardens

Number and names of trainees unknown.

7.30 - 9.00pm Team meeting with Board Chairmen and local supervisors of surgical training

Number and names of supervisors unknown.

Thursday, 31 May

The AMC has booked a meeting room at the Medical Practitioners Board of Victoria from 8.00 am to 4.00pm.

Please note that the accreditation team will split into two groups during this period, one for the meeting with College staff and the second group will be in a teleconference with New Zealand trainees.

10.00am - 12.00md Meeting with College staff who support the College's education, training and professional development activities. Council Room, Surgeons Building. (Half team)

10.00 am – 12.00 md Hailes Room (12.00 noon – 2.00 pm New Zealand time)

Teleconference with New Zealand trainees.

Executive Officer, RACS New Zealand Office, will be co-ordinating the teleconference.
Project Officer – Accreditation (attendance for part of the meeting)

* From Melbourne call free phone: 1800 505 427 at the designated time
* Key in four digit number: 4810

6.00pm Feedback to the College on the team's preliminary findings (College to arrange for Office Bearers to be available for teleconference)

The Censor in Chief, Professor R West is unavailable for the teleconference.

Friday, 1 June

8.30 am - 12.30 pm Meeting of the Team
Medical Practitioners Board of Victoria

ITINERARY FOR ACCREDITATION VISIT OF
DR ROBIN MORTIMER AND PROFESSOR JOHN GIBBS
AUSTRALIAN MEDICAL COUNCIL
TO QUEENSLAND
TUESDAY, 22 MAY AND WEDNESDAY, 23 MAY 2001
MONDAY, 28 MAY AND TUESDAY, 29 MAY 2001

Tuesday, 22 May 2001

Toowoomba General Hospital

0930 hours	Meeting with Director of Surgery	
1000 hours	Meeting with Supervisors of Training (all specialties) and surgeons at the Toowoomba General Hospital	
	with morning tea	
1100 hours	Meeting with:	Registrars-in-training Registrars (non-training) Basic Trainees Part 1 holders but not yet on a Training Programme Any overseas trained surgeons who have been assessed via the College/AMC pathway
1200 hours	Meeting with:	Director of Intensive Care and A/Director Accident and Emergency
1230 Hours	Meeting with:	Exec. Director of Medical Services Director of Nursing Services
1300 hours	Lunch	
1400 hours	Departure to drive to Brisbane	

Wednesday, 23 May 2001

Gold Coast Hospital

0930 hours	Meeting with Director of Surgery
1000 hours	Meeting with Supervisors of Training (all specialties) and surgeons at the Gold Coast Hospital Any overseas trained surgeons who have been assessed via the College/AMC pathway
	with morning tea

1100 hours	Meeting with:	Registrars-in-training Registrars (non-training) Basic Trainees Part 1 holders but not yet on a Training Programme
1200 hours	Meeting with:	Director of Intensive Care Director of Accident and Emergency
1230 hours	Meeting with:	Medical Superintendent Director of Nursing
1300 hours	Lunch	
1400 hours	Departure to drive to Brisbane	

Monday, 28 May 2001

Logan Hospital

0930 hours	Meeting with Director of Surgery	
1000 hours	Meeting with Supervisor of Training and surgeons at Logan Hospital	
1030 hours	Meeting with:	Registrars-in-training Registrars (non-training) Basic Trainees Part 1 holders but not yet on the Training Programme Any overseas trained surgeons who have been assessed via the College/AMC pathway
	with morning tea	
1100 hours	Meeting with:	Director of Intensive Care Director of Accident and Emergency
1130 hours	Meeting with:	Medical Superintendent Director of Nursing
1200 hours	Lunch	
1300 hours	Depart to drive to Princess Alexandra Hospital	

Princess Alexandra Hospital

1330 hours	Meeting with Chairman, Division of Surgery	
1400 hours	Meeting with Supervisors of Training (all specialties) and surgeons at Princess Alexandra Hospital	
1500 hours	Meeting with:	Registrars-in-Training Registrars (non-training) Basic Trainees

		Part 1 holders but not yet on the Training Programme Any overseas trained surgeons who have been assessed via the College/AMC pathway with afternoon tea
1600 hours	Meeting with :	Director of Intensive Care Director of Accident and Emergency
1630 - 1700 hours	Meeting with	Exec. Director of Medical Services Director of Nursing Services

1800 hours *Meeting and Videoconference:*

At: *College Building,*
50 Water Street,
Spring Hill,
Brisbane

With: *registrars-in-training/non-accredited registrars (all specialties)/ Intermediate trainees*
(Part 1 Holders) basic trainees etc. who have not been interviewed at site visit hospitals

Light refreshments will be served

Tuesday, 29 May 2001

College House, 50 Water Street, Spring Hill, Brisbane

Buffet Breakfast

0700 hours	Meeting with Board Chairmen and local Supervisors of Surgical Training
0800 hours	Select meeting with representatives of the Australian Orthopaedic Association (Qld Branch)/Board of Orthopaedic Surgery/ Training Committee of the A.O.A.
0845 hours	Departure to drive to Brisbane Airport

Definitions

Accreditation review

The activity undertaken by the Specialist Education Accreditation Committee and its accreditation team in examining the specialist education and training program of a training organisation.

Accreditation outcome

The decision of the AMC concerning the specialist training program of a training organisation, generally in accordance with the four possible accreditation outcomes, and drawing on the recommendations of the Specialist Education Accreditation Committee.

Assessment

The set of policies and processes by which a specialist medical training organisation assesses the progress and performance of individual trainees. This includes both continuous formative assessment (feedback) and summative assessment, which is used to determine progress and certification.

Similarly, the set of policies and processes by which the AMC assesses the basic medical training of an overseas trained doctor. Similarly, the set of policies and processes by which a training organisation assesses the training and experience of an overseas trained specialist.

Evaluation

The set of policies and processes by which a college evaluates the extent to which its specialist training program is achieving its aims; and which, it is proposed, will form the basis of the AMC's accreditation process.

Similarly, the set of policies and processes by which the AMC itself evaluates its accreditation of specialist education and training programs.

Outputs and outcomes

An outcome is a measure of effectiveness, that is, an outcome should be related to a specific objective eg to produce a safe and competent specialist.

An output is a measure of efficiency, that is, it is related to resources used in producing it. For example, a training organisation manages an annual program of trainees (outputs) using examiners, supervisors, and staff (inputs).

Usually, inputs and outputs are easier to measure than outcomes, and therefore people tend to favour efficiency measures. It is possible, however, to have a highly efficient program but not be meeting all, or any, of the stated objectives, therefore failing on the effectiveness test.