ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Medical Council of New Zealand

Reaccreditation 2010

Date of last MCNZ assessment: February 2004

Reaccreditation due: December 2010

College details

Name: Royal Australasian College of Surgeons

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

Officer to contact concerning the report: Professor Bruce Barraclough
Telephone number: +61 3 9276 7468
Email: bruce.barraclough@surgeons.org

New Zealand Office:
Elliot House
43 Kent Terrace
WELLINGTON SOUTH 6011

PO Box 7451, Newtown 6242

Officer to contact concerning the report: Ms Justine Peterson
Telephone number: +64 4 385 8247
Email: justine.peterson@surgeons.org

Table of contents

A. ADMINISTRATION AND GOVERNANCE

The Royal Australasian College of Surgeons (the College) is governed by a Council of 25 elected members representing all regions in Australia and New Zealand and the nine surgical specialties relevant to this College (each of these specialties is a recognised vocational branch of the MCNZ). The College's constitution requires that there must be no less than two elected Councillors from New Zealand. There are three co-opted members (two appointed Expert Community Advisors and the Chair of the RACS Trainees' Association (RACSTA)). At each Council meeting there are invited observers, these include the President of the Australian and New Zealand College of Anaesthetists and the Chair of the Younger Fellows Committee, plus Regional Chairs on a rotational basis. Committee members serve in an honorary capacity.

The College revised its Constitution through 2009 and a new version was accepted formally at the Annual General meeting in May 2010. Although many of the alterations were to modernise the language and approach of the Constitution it introduced some key changes. One of these is that the Chair of the Trainees Association is now a formal co-opted member of Council with full voting rights, except for votes concerning Office Bearer positions.

Consequently, the role of trainees in College activities and decision making has continued to advance with a vital committee (RACSTA Board) structure supported by management and Councillors, presence on all training and educational committees (apart from the Court of Examiners) and now formal presence on the Council of the College. Given the substantial time pressures on trainees, the College is indebted to RACSTA for their enthusiasm and commitment which in some cases extends over many years. The current Chair of RACSTA is Dr Greg O'Grady, who is a General Surgery trainee from New Zealand.

The main Boards and Committees report to Council. These are led by Councillors and their membership includes Councillors, other College members and, on occasion, co-opted non members. These Boards and Committees have subsidiary Boards and Committees reporting to them and are comprised of College members; and some also include non-members. There are New Zealand based members on all these Boards / Committees.

The senior governance committee of the College in the Education portfolio is the **Education Board** (EB). (see attached diagram Appendix 2). It is chaired by the Censor in Chief (Professor Mark Edwards). The New Zealand Censor, Dr Catherine Ferguson is on that committee along with the Chairs of the various committees reporting to EB, and other members of Council and the External Community Advisor (Professor David Barr, AM).

The governance of the College educational programs has continued to evolve. The functions of the Basic Surgical Training (BST) Board have now been absorbed into other areas as the BST program is formally closing at the end of 2010. The BST trainees have now either been accepted into one of the nine Surgical Education Training programs or have explored other career pathways.

As expected the **Skills Education Committee** is becoming more prominent and Mr Phil Truskett continues to chair this committee. One of the important activities now oversighted by this group is to accredit external courses or programs that would be relevant to the training of surgeons. It is anticipated that courses focused on the basic clinical sciences like Anatomy, Physiology, Pathology and Biochemistry and have often been accredited will be progressively accompanied by more courses focusing on surgical skills, care of the surgically unwell or emergency care. The accreditation process of the College reviews both the relevance of the program to surgical trainees, its capacity to be delivered reliably and whether it is comparable to components of the surgical education and training program that are currently delivered through the College or its partners.

The **Court of Examiners** is undertaking a substantial review of its activities with working parties established to review the structure of the examination and timing of components, the active alignment between the assessment processes and the curricula for the trainees and the methodology / support that is required from a logistical and information technology perspective. The Court is currently chaired by Professor Spencer Beasley.

The **Board of Surgical Education and Training** (BSET) is chaired by Dr Simon Williams and oversights the nine training boards that are responsible for the delivery of the actual training programs. These continue to be defined by Memoranda of Understanding and Service Agreements between the College and the thirteen Speciality Societies and Associations who act as the agents in delivering the program. All the thirteen Societies and Associations are autonomous bodies with their own governance structures. Over the past twelve months the Australian and New Zealand Vascular

Society (ANZSVS) went through a re-incorporation process and accepted responsibility for administering their program directly.

The SET program was the focus of a review workshop earlier in the year. Major issues are being addressed by working parties reporting through to the Board of SET in conjunction with the individual training boards providing responses.

The **Post Fellowship Education and Training Committee** (Chaired by Dr Hugh Martin, AM) is now involved with the formal accreditation of courses or formal training programs that are occurring in the Post Fellowship arena. A number of programs are being prepared by external groups for formal review by this committee. To date the Neurosurgical Society of Australasia (NSA) post fellowship program in spinal surgery has been reviewed and formally approved by Council. This review confirms that the curricula of the program and assessment are appropriate, capacity issues have been addressed and that regular monitoring and reporting will occur. The programs do not speak to "ownership" of operative procedures or specific domains of competence. It is accreditation of a specific program and it is expected that in some areas a number of programs will be accredited formally by the College.

The senior governance committee in the Fellowship portfolio is the **Professional Development and Standards Board**. This is chaired by Professor Guy Maddern. The **Professional Standards Committee** (Chaired by Professor Grigg) continues to oversight the Continuing Professional Development (CPD) program. With the introduction of the national Medical Board of Australia and compulsory CPD it is anticipated that issues of non-compliance will become more significant. The College is more formally handling issues of Code of Conduct breaches. The Code of Conduct concerns relate frequently to areas of professionalism and behaviour as well as technical skills. In handling these the College takes an educational model where the offending trainee or Fellow is reminded of their ongoing commitment to the Code and they sign a Statutory Declaration of adherence and acceptance that if the Code is breached again then their Fellowship or place on the training program may be rescinded.

The **Professional Development Committee** (Chaired by Professor Vonau) continues to oversight the development of training programs specifically aimed at the non-technical competencies for Fellows. As an example the program for Surgical Supervisors has developed modules in the assessment of trainees, the interviewing processes for selection and is now developing a program of providing support to marginal trainees. Importantly these programs will be of the rigour that they will be recognised for prior learning in the Graduate Diploma for Surgical Educators that is being developed between the College and the Royal Melbourne Institute of Technology (RMIT University), and the Master of Surgical Education that is being developed with the University of Melbourne.

The **Academy of Surgical Educators** has now been established. The Board of the Academy is chaired by Professor Vince Cousins and specifically includes a number of external medical educationalists to bring vigour to our ongoing considerations of the College programs. The Academy has a key Advisory Committee chaired by Dean of Education (Professor Bruce Barraclough AO). Issues such as general membership of the Academy have now been resolved and the aim is to utilise the skills of the Academy Board and Advisory Committee to ensure the educational programs and in particular the assessment processes are progressively reviewed and where appropriate updated.

Changes to the training resources and educational resources

Professor Bruce Barraclough AO commenced in the role of Dean of Education in October 2009. Major initiatives now underway include progression of the Academy of Surgical Educators (see above), developing major links with a number of Universities and some of the other post-graduate medical colleges to expand opportunities for surgical education and thirdly the re-vamping of our on-line educational capacity. In this last area, the College is now placing significant investment to provide a revitalised web presence and provide access to on line learning.

The requirement for more capacity in the on line learning area will require not only new infrastructure in the form of hardware and software but also in the educational staff profile. Additional staff has been appointed to the Academy of Surgical Educators and also the creation of a position of e-learning manager has occurred. It is anticipated that further organisational change will be required to fully support these on line initiatives.

The Dean of Education now holds regular meetings with all College staff involved in the educational development portfolio to ensure a cohesive approach to all the educational initiatives, debriefings and

updates on key relationships of College related groups, Specialty Societies and external educational providers such as the Universities.

In the last few months the College has developed a process for **accreditation of courses** which are suitable for trainees. A range of courses offered by the College, specialty boards and universities have already been submitted for accreditation.

The administration and management of the College is aligned with the governance structure and is led by the Chief Executive, Dr David Hillis. The administrative sections are led by a Director(s) and align to the four key portfolios of the governance structure. The New Zealand office conducts activities related to all four portfolios and is based within the Relationships portfolio.

B. THE TRAINING PROGRAM

There have been many changes to the surgical training program since the MCNZ 2004 re-accreditation. The most significant of these has been the change from two separate programs - Basic Surgical Training (BST) and Specialist Surgical Training (SST) - to one single program - Surgical Education and Training (SET).

Changes to the structure of the training program since 2004

In 2004 surgical training was in two parts. The generic Basic Surgical Training (BST) program could be applied for during PGY1. Those selected had a minimum of two years and a maximum of four years to complete that program. Having completed all of the requirements of BST, trainees could apply for selection into one of the nine Specialist Surgical Training (SST) programs (4–6 years minimum duration, depending on the specialty).

No appointments have been made to the BST program since 2006 and this program will be completely phased out by 31 December 2010. As of 31 October 2010 there are four registered BSTs in New Zealand. One has been accepted into a specialty training program starting in 2011. The remaining three will cease to be registered trainees of this College at the end of this year.

Selection for the first intake of Surgical Education and Training (SET) trainees was in 2007, to commence their training in 2008. Doctors interested in a surgical career now apply from PGY2 onwards for selection directly into one of the nine surgical specialist SET programs (see Table 1 below for the duration of SET training in each of the specialties). The early SET years incorporate some elements of the former BST program including courses and generic clinical and basic sciences examinations.

Table 1: Duration of training for each surgical specialty for trainees commencing in 2010 and 2011

Training requirements	**Total number of years**		**Years in General Surgery or surgery in general**		**Years in Specialty**	
	2010	**2011**	**2010**	**2011**	**2010**	**2011**
Cardiothoracic Surgery	6	6	1	0	5	6
General Surgery (Australia & New Zealand)	5	5	NA	NA	5	5
Neurosurgery *	6	6	0	0	6	6
Orthopaedic Surgery (Australia & New Zealand)	5	5	0	0	5	5
Otolaryngology Head & Neck Surgery (Aust & NZ)	5	5	1	0	4	5
Plastic & Reconstructive Surgery (Aust & NZ)	5	5	0	0	5	5
Paediatric Surgery	6	6	2	2	4	4
Urology	6	6	2	2	4	4
Vascular Surgery	5	5	1	0	4	5

* includes one full year of research for all trainees

These changes in the structure and timing of the training programs have resulted in a rewrite of curricula, of training policies and procedures and of specialty program regulations. The revised policies include "Assessment of Clinical Training" (with information on what is required if a trainee's performance is considered unsatisfactory), "Surgical Trainers" and "Surgical Supervisors" (these detail the responsibilities of the Hospital Supervisors and of the surgical trainers). Each specialty program continues to review and improve its trainee assessment forms. These are gradually being moved to online forms, as are the specialties' operative logbooks.

The MCNZ may have viewed all these documents through its participation in the most recent reaccreditation processes by the Australian Medical Council (AMC) in 2007. If further copies are required, the College will be happy to provide access via the web on request.

The outcomes of the training program

Although the structure of the program has changed, there has been no change to the purpose or mission of the College which is:

> As a fellowship based organisation, the Royal Australasian College of Surgeons commits to ensuring the highest standard of safe and comprehensive surgical care for the community we serve through excellence in surgical education, training, professional development and support.

There has also been no change to the statement of graduate outcomes or results of the training program which is:

> The College requires that all trainees and Fellows are competent in the following nine areas of competence:
>
> - Medical Expertise
> - Technical Expertise
> - Judgement – Clinical Decision Making
> - Professionalism and Ethics
> - Health Advocacy
> - Communication
> - Collaboration
> - Management and Leadership
> - Scholar and Teacher

Trainee numbers

The number of trainees selected into each specialty each year has traditionally been based on the number of posts vacated in that specialty at the conclusion of the current year. Reasons for vacancies include trainees progressing to Fellowship, withdrawals, transfer to another specialty program and taking leave of absence. In some years, in some specialties, additional posts become available when a new training post is nominated by a hospital and accredited by the specialty board as meeting the accreditation requirements and offering an appropriate case-load and case-mix.

In SET the same formula is being applied to identify the number of trainees to be selected each year.

The disparity between the number of specialty training posts and the number of suitable applicants for positions continues. The College has requested that over 50 new training positions per year be established but very few new positions have been forthcoming from hospitals. The College is working cooperatively with the Department of Health and Ageing (DoHA) in Australia, and the Health Workforce New Zealand (HWNZ) to identify new posts in both public hospitals and in the private sector. Therefore, although there has been an increase in the number of individuals applying for SET, there has been no change in the proportion of training positions available to the number of applicants for positions.

- In 2008, 742 individuals made 1017 applications for selection across the nine specialities for 321 positions
- In 2009, 798 individuals made 1108 applications for selection across the nine specialities for 270 positions
- 1n 2010, 861 individuals made 1132 applications for selection across the nine specialties for 254 positions

Selection

There has been considerable standardisation of selection processes across the nine specialties of this College. It is accepted that there may be different eligibility criteria and that certain aspects of experience may be given different emphasis by different specialties. However, all programs utilise the same three selection tools (structured CV, referees reports and semi structured interviews); each tool is scored within agreed minimum and maximum parameters; and the information on all eligibility requirements, selection tools and policies associated with selection are publicly available on the College website.

The College continues to review and refine the selection processes and is soon to begin research into successful applicant's scores on the three selection tools vis a vis their progress on the training program.

Selection into surgical training is very competitive – as shown in the figures above, and in Tables 3-7 in Appendix 3.

Selection to the SET program occurs nationally (separately in Australia and New Zealand) in some of the larger surgical specialties (General Surgery; Orthopaedic Surgery; Plastic and Reconstructive Surgery and Otolaryngology Head and Neck Surgery), and in the other surgical specialties as a bi-national (single selection and intake for both Australia and New Zealand) activity.

In 1998 the College endorsed the Best Practice Framework for trainee Selection that subsequently became known in Australia as the **Brennan Principles** which continue to underpin the College trainee selection principles as outlined below:

- Selection processes for surgical education and training must comply with AMC and MCNZ accreditation requirements and the Brennan Principles
- Selection processes must be merit based, free of bias and, to the greatest possible extent, quantifiable
- Selection processes must be compliant with relevant Australian and New Zealand laws and the principles of natural justice and procedural fairness
- Selection processes must be open to external scrutiny and conducted in an accountable manner using documented processes
- Selection processes must be conducted on a national or bi-national basis in Australia and New Zealand
- The opportunity to apply for selection must be publicised in a manner which creates awareness of opportunity for all eligible applicants
- Criteria in all of the tools must be related to objectives of the training program and the desired attributes of graduates.

Selection into SET

With the introduction of SET there have been changes to the:

- level of postgraduate training at which medical graduates can apply for selection into specialist surgical training.
  - The SET program allows the earliest applications to be made from PGY2 for commencement in PGY3. It is not however assumed that all applicants will apply from that level of training. Applications can also be made by medical graduates (including BST Trainees and Fellows) at any time beyond PGY2.
- eligibility criteria (see below)
  - International Medical Graduates are eligible to apply to SET provided that they can satisfy the relevant eligibility requirements.
- the number of times that people can apply
  - There are no limits to the number of times that a person can apply to SET, and no limit to the number of specialties applied for. Unsuccessful applicants will be advised about their application, with counselling and strong career advice being given to any applicant who has made three unsuccessful applications to the same specialty.
- the process of registering for selection
  - Doctors intending to apply for selection into SET must register for selection. The details on each candidate's registration will be used to determine if the minimum eligibility criteria have been met. Only those who meet these registration requirements will be allowed to progress to the next step of submitting a full application.
- the varying timing of selection between specialties and also between New Zealand and Australia

Eligibility criteria

Any person wishing to apply for selection into the training program of one (or more) of the surgical specialties must fulfil all of the general eligibility criteria, plus the eligibility criteria for the specific specialty (or specialties) for which they are applying. If the applicant does not meet all of those criteria their application will not be considered.

Generic eligibility criteria

There are two eligibility criteria which apply across all nine specialties:

1. Permanent residency or citizenship of Australia or New Zealand at the time of registration
2. General (unconditional) registration in Australia or general scope or restricted general scope registration in the relevant specialty in New Zealand

All generic eligibility requirements must be satisfied at the time of registration. At the time of registration applicants must consent to a full criminal history check including submission of relevant documentation on request to enable this to be undertaken.

Specialty specific eligibility criteria

A detailed list of the specific eligibility criteria for each specialty is provided on the College website prior to the commencement of the selection process.

Selection tools

Specialty Boards must receive annual approval from the Education Board for the selection tools they use and the weighting given to each tool.
Within an accepted range defined in workshops on improving the selection procession (2007 & 2009), each specialty decides:

- The comparative weighting of the CV; Referee Reports; and Interview
- Any minimum acceptable score
- The number of trainees they can accept into their program (based on the projected number of available accredited hospital posts)

A detailed list of the tools and the weighting of the different components for each specialty is made available on the College website prior to the opening of selection.

The College provides a training program for interviewers to ensure that there is shared understanding of the process and selection criteria.

Feedback to unsuccessful applicants

All unsuccessful applicants are provided with written feedback on their standing and performance in the application and selection process. Any applicant who has had three unsuccessful attempts in applying to the same specialty receives strong advice on their professional options.

Curriculum content

The goal of Surgical Education and Training (SET) is to train surgeons to the point where they are competent to practice independently and safely and provide the highest standards of specialist care to their patients. The College continues to work with a number of National, State and Territory Government departments and working groups to review the goals of surgical education and training within the broad spectrum of delivery of services within the Australasian health systems. As trainees are located in various regions in a bi-national training program, the College utilises a combination of face to face, computer assisted and distance learning educational resources in a range of settings including hospitals, skills centres and universities.

The College and specialties have well-developed content and assessment for training. However, the aim of more recent curriculum development has been to develop clearly articulated learning objectives regarding what the trainee should be able to do, and competencies necessary to practise as an independent surgical specialist in the Australian and New Zealand health systems. Therefore the focus in recent years has been on linking content with objectives and desired competencies and to appropriate assessment procedures.

Program Overview

Specialist surgical training programs for SET are developed and supervised by the College, through the agency of the surgical boards and the regional surgical training committees.

All of the specialist surgical training programs in SET have a minimum duration of five years with trainees being required to successfully complete every rotation, to fulfil the research requirement, and pass the examinations.

SET is a combination of interconnecting and complementary elements:

- Competencies (as outlined above)
- Clinical experiences
- Modules
- Courses
- Research
- On-line training resources
- Assessment – both formative and summative
- Surgical supervisors
- Accredited training posts

Figure 1 (below) is a diagrammatical representation of the interconnectedness of the various components of surgical training.

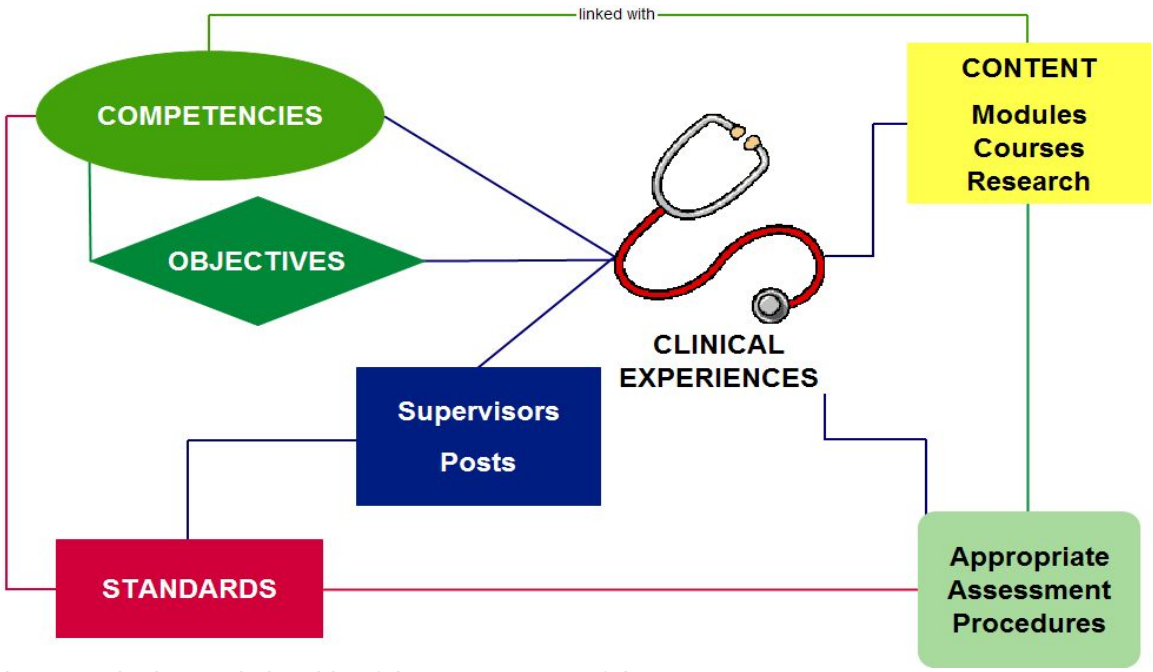

Figure 1: The inter-relationship of the components of the SET program

Clinical Experiences

It is recognised that, for any trainee, a single training post will not offer complete training. Several posts are usually required to obtain sufficiently wide experience. Such a combination of training posts constitutes a training program.

For each rotation specialty trainees are allocated to train in an accredited training position or post. It is the responsibility of the specialty boards to manage the allocation of trainees across the available posts to ensure that each trainee gains the widest possible experience and achieves the required case-mix in line with the modules.

Modules

The modules have been developed by the College and Specialties to encompass and define all of the competencies — all of the knowledge, skills and attitudes which are required to be achieved by every trainee. Within the modules the competencies are stated as specific outcomes or objectives, plus the standard at which those competencies are expected to be performed.

Because of the complexity and variety of the required training, in most specialties there is no pre-defined order or sequence for the completion of the modules. The area or areas that they focus on in a given rotation are defined by the work in the unit to which they are allocated.

Courses

The College offers five courses which have been developed over many years:

- Trainees in BST were required to complete ASSET, CCrISP and EMST
- CLEAR and STATS were taken in either BST or SST

The courses are recommended to be taken in this sequence to correlate with trainees' increasing knowledge and clinical experience. In SET most of the specialties state that they will require their trainees to complete ASSET and CCrISP in SET1, with several also nominating EMST to be taken in either SET1 or SET2

Each course contributes to trainees' overall clinical knowledge and understanding in different ways. Participants are provided with mentoring and assessment of performance beyond the courses through feedback to their surgical supervisors identifying candidates with exceptional abilities; those who failed the course, and those in between who require further development and guidance.

Research

An investigative project is mandatory for all surgical trainees prior to presenting for the Fellowship Examination. One or more of the following is required:

- presentation of a paper or poster display to a meeting for which abstracts are subject to review and selection
- a publication in a journal which referees all manuscripts
- a dissertation with a written review of a clinical problem, together with a critical literature review
- a period of full-time research
- a higher degree

The project should be certified as completed by the regional committee of the appropriate surgical board, and this certification forwarded to the board prior to the trainee being accepted to present for the Fellowship Examination.

Trainees can apply for research leave, and/or to undertake a higher degree as part of their training program. A case for the crediting of a research program as a component of a specialist surgical training program must be lodged and approved, normally in advance, by the specialty board.

The College offers a number of opportunities for trainees who are wishing to do research contributing to a higher degree, or to travel to further their training or research. The Board of Surgical Research of the College Council is responsible for assessing applications for Fellowships and scholarships and the Foundation for Surgery manages an increasing number of scholarships which are open to both trainees and Fellows wishing to enrol in a higher degree – usually a PhD. http://www.surgeons.org/Content/NavigationMenu/Research/Scholarshipprogram/Scholarshipandfellowshipopportunities/Research_Scholarship2.htm Currently there are 17 scholarship holders enrolled in a PhD and 3 more intending to enrol.

On-Line Training Resources

The College and specialty websites function as timely sources of information and communication, providing clear indications of what is expected of trainees during and on completion of the program. This includes information on program content (modules), assessment requirements and proforma, plus significant dates.

The College is currently undergoing a substantial up-grade of the website, including their training resources. This is increasingly becoming an area where trainees are able to participate in curriculum assessment and receive real-time transcripts of their training status.

Accredited Training Posts

The specialty training boards monitor the quality and outcomes of training in each post. They do this through their regular hospital accreditation processes and also through information drawn from trainees' logbooks and, in some specialties, the Trainee Evaluation processes.

Posts are only accredited when they are recognised as being able to offer appropriate training opportunities including case load, case mix and supervision.

Specialty Boards allocate trainees to accredited hospitals. Within the hospital the trainee will nominate their preferred rotations, and the hospitals will arrange the rotations in consultation with the College when necessary.

There has been no change to the way in which trainee's requests for flexible training and recognition of prior learning are addressed by the specialty boards.

Assessment

Formative assessment

Formative assessment is ongoing and has the specific purpose of providing the trainee (and supervisor) with immediate feedback with the intention of improving their performance. The in-training assessment forms for each specialty reflect their statement of required competence.

The surgical supervisor and the regional committee of the relevant specialty board are responsible for the in-training assessment of specialist surgical trainees. All specialties have mid-term in-training assessments with formative feedback and also a formal assessment at the completion of each six month term.

There is a variety of formative assessment processes being implemented. For example:

- Informal formative assessment is frequently given during ward-rounds and during surgery.
- Formal formative assessment is increasingly becoming part of the suite of assessment processes in each surgical specialty.

The completion of the end-of-rotation In-training Assessment forms can be interpreted as either a formative or summative assessment depending upon the opportunity for follow-up.

If there is no opportunity for trainees to improve their performance after the assessment and no flow-on process into the following rotation, then each separate rotation could be seen as a separate summative assessment rather than being formative.

Work-place-based competency assessment

Experience in other countries has clearly demonstrated the benefits of using checklists and global rating scales as workplace assessment tools. Tools which have been thoroughly trialled and validated and which are under discussion include those available for the assessment of procedural skills, clinical examination of a patient, discussion of a case, clinical decision making, and teamwork. It is not intended that these assessment processes would add significantly to the time commitment for supervision. These assessment processes are designed to complement the time that trainees and supervisors are already working together in theatre, in wards, or on rounds. These assessments are expected to make the mid-term and end-of-term assessments more valid and reliable because the decisions can be based on documented evidence collected throughout the rotation.

Trainees, with the support of their supervisors, are responsible for ensuring that they are assessed the required number of times during each rotation, and across the year, and for maintaining a record of these assessments in their portfolios.

To enhance the current range of formative assessment tools, the College is encouraging the Specialties to gradually introduce the following workplace competency assessment processes.

Technical Expertise

Direct Observation of Procedural Skills (DOPS) and Procedural Based Assessment (PBA)
DOPS and PBAs involve the observation of a surgical procedure by a supervisor. DOPS was designed to be both a formative and summative assessment process that was feasible, reliable and valid in assessing surgical skill in basic surgical procedures.

PBAs differ from DOPS in that they are generally used to assess intermediate and advanced surgical procedures.

In addition some specialties have developed specific tools to assess performance in key procedures.

Log books
All of the specialties have log books which have been reviewed to reflect the requirements of the modules defined for the current specialty training programs.

Judgment – Clinical Decision Making and Communication

Mini Clinical Evaluation Exercise (Mini CEX)
The Mini-CEX is an assessment tool designed to assess the provision of good clinical care. The process involves an assessor observing the trainee interact with a patient in a normal clinical encounter. The assessor uses a structured checklist to provide formative feedback to the trainee.

Case–Based Discussion (CBD)

A CBD involves a discussion between a trainee and their supervisor (or clinical group) about one of their clinical cases that challenge the trainee (as opposed to a routine case).

Collaboration, Health Advocacy and Professionalism and Ethics

360° assessment or Mini Peer Assessment Tool (Mini PAT)
The 360° assessment, Mini PAT or Multi-source Feedback Assessment (MFA) is a widely used process to gain information about a trainee from people other than their specialist supervisors. Assessors can include registrars, nursing staff, and other medical consultants.

Summative Assessment

Summative assessment can occur at any stage of a training program although it usually occurs towards the end of a defined area of study or course. This process can be used to provide feedback for the trainee, and information for reporting to people outside the training situation.

Since 2004 there has been significant progress in restricting summative assessment to processes and times which are most appropriate within the training programs. The examinations have been clearly identified as the key summative assessment processes. In SET there are two stages at which all trainees undergo summative assessment (i.e. examinations). The early examination is generally in the first two years of SET with generic examinations in surgical sciences and clinical skills, plus a specialty specific surgical sciences examination. The second stage occurs at the end of training when a pass in the Fellowship Examination remains an essential requirement of surgical training.

Generic Basic Sciences Examination and Clinical Examination

Building on the extensive work which has been carried out over several years to establish the BST examination, the SET1&2 examinations use a number of different standard setting methods to ensure that the processes are valid and reliable.

The generic Surgical Sciences Examination (SSE) uses MCQ format to test knowledge of Anatomy, Pathology and Physiology. This written examination, which is offered twice a year at locations around Australia and New Zealand, consists of 2 x two and a half hour papers, each of 120 multiple choice questions drawn from the disciplines of Anatomy, Physiology and Pathology. A minimum standard is required in each of the Anatomy, Physiology and Pathology Sections of the examination, at the same sitting, before a candidate can be deemed to have passed the Surgical Sciences Generic Examination.

The generic Clinical Examination is a practical examination, using OSCE format. The emphasis of the Clinical Examination is on the application of basic science knowledge and understanding and clinical practice relevant to all forms of surgery. Trainees spend five minutes at each of 16 assessed stations. Examples of tasks include patient history-taking and examination, demonstration of practical technical skill, the application of basic science knowledge, data acquisition and analysis, counselling and communication skills. At each station the candidates are observed by examiners. The Clinical Examination is offered twice per year at locations around Australia and New Zealand.

The purpose of these examinations is, as part of the continuum of learning and assessment, to assure both the trainees and their supervisors that they have achieved a standard of knowledge and clinical decision making that enables them to continue training within their specialty.

If a trainee has not successfully completed both of the generic examination components, and in some specialties (see below) the specialty specific examination, by the middle of their SET2 year, they will be dismissed from the program.

Specialty specific surgical sciences examinations

The content (anatomy, pathology and physiology) and timing of the specialty specific examination is determined by each specialty. The specialties which had an MCQ examination early in specialty training (SST) (Orthopaedic Surgery, Plastic and Reconstructive Surgery, and Paediatric Surgery) prior to the introduction SET continue to assess their trainees in SET3/4. All of the other specialties have developed their MCQ examinations in association with the committee which who develop the generic examination and, whilst being a single paper for each specialty, they are run at the same time, and under the same regulations, as the generic examinations.

Fellowship Examination

A pass in the Fellowship Examination (FEX) is the final summative assessment requirement for all specialties. Trainees must be approved as eligible to sit by the relevant specialty board on each occasion that they present for the examination.

The FEX is an assessment of the trainees advanced clinical knowledge and in particular their competence in Judgement- Clinical Decision Making.

The Court of Examiners is appointed by the Council of the College to conduct the Fellowship Examination and to assess the knowledge, clinical skills, judgement and decision making, and professional competencies of candidates, in order to ensure that they are safe and competent to practise as surgeons.

The Court is comprised of surgeons representing the 9 different specialties in which the College conducts the Examination. The number of Examiners varies in each specialty in line with the number of trainees and examination candidates.

The clinical/oral examinations are conducted during May and October each year and are rotated between four centres in Australia; and between four centres in New Zealand.

Written exams are normally conducted in April and September each year in each of the capital cities in Australia (except Darwin) and four centres in New Zealand.

Identifying and managing the underperforming trainee

A feature of SET is the emphasis on the early identification and management of underperforming trainees (as previously indicated under work-place-based assessment)

During each rotation, trainees are required to meet the required standard of performance, against each performance indicator, across all of the nine competencies. Unless it is a breach of professional behaviour, or academic misconduct, which could result in immediate dismissal from the program, a trainee who is identified as not meeting those standards will be given a limited number of opportunities to attain the required standard. During that time they will be given clear guidance as to what is required. Failure to attain the required standard in the identified competence area, or poor performance against any other competence criteria could lead to dismissal from the program.

Please refer to the following policies accessible from the College home page via: Policies - Education – Surgical Education and Training

Assessment of Clinical Training

Dismissal from Surgical Training Policy

Identification and Management of Academic Misconduct

To enhance the knowledge and skills of Supervisors and Trainers the College has now developed two training programs specifically focusing on trainee assessment and managing the under-performing trainee. The first course Supervisors and Trainers for SET (SAT SET) was launched in May 2007 and so far has been attended by over 1500 Fellows. The next course, Keeping Trainees on Track (KTOT) will be launched in May, 2011.

Some specialties have introduced addition support materials for their supervisors. These include:

- General Surgery Training Board has introduced a performance management pack which is distributed through their Regional Subcommittees. This has enabled a streamlined approach to performance management, providing support to supervisors so that the required processes are easy to follow, timely and fair for trainees.
- The Orthopaedic Board has developed a flowchart and form letters to assist their supervisors.
- In Vascular Surgery, if a trainee's performance is assessed as unsatisfactory, a 360 degree assessment will be required. The 360 degree assessment is also available to supervisors if they have a satisfactory trainee but want to broaden the trainees awareness beyond technical skills

Monitoring and evaluation of the training program

The specialty boards carry out regular reviews of their curriculum content, teaching and learning activities, and assessment processes. On the basis of these reviews the curriculum is up-dated to reflect changes in the profession and the development of new assessment and management techniques.

Trainees' opinions of the programs are currently monitored by several of the specialty training boards:

- The Neurosurgery training position evaluation form is completed by trainees at the end of each 6 month rotation.
- Otolaryngology Head and Neck Surgery have asked their trainees to fill out performance reports on rotations which are not felt to be up to standard and some of these posts have been placed on probation
- The Board of Plastic Surgery has evaluation forms which are available for the trainees to fill out on-line after each clinical rotation at each hospital. This is for the trainee to evaluate the quality of training provided in each rotation
- The Urology board is planning to introduce a Trainee's Forum comprising trainees from each region and SET level. This forum will enable trainees to provide feedback on all aspects of the program and will provide an avenue for them to propose recommendations for program enhancements.

A new trainee evaluation form has been developed by RACSTA. This will be available to be used across all of the surgical specialties from the end of 2010. To provide greater anonymity for the trainees this survey will be analysed within the College and the Specialty Boards will receive only the collated results.
The College has encouraged the surgical specialties to develop processes of collecting regular feedback from their trainees. However, because the specialties evaluation forms are designed to provide information about the specific training posts, this poses a potential problem around anonymity for trainees in smaller posts and/or surgical specialties. The Board of SET has therefore supported the development of the RACSTA evaluation form because it will potentially provide different data from the specialty specific evaluation forms.

Potential changes to the SET training program

The College continues to monitor the progress of the nine SET programs and to explore ways in which this may become a more truly competence based (as opposed to minimum time based) training system. This included a comprehensive review and two day workshop in April, 2010. From that workshop the nine specialty training boards were asked to investigate possible changes to transition the SET Program from time-based training, to full competency based training. In their investigations the boards were requested to consider the following:

- Revised assessments to enable reports to identify the incompetent; the slow but satisfactory learner; the "normal" satisfactory learner; and the advanced trainee.
- Changes to the Dismissal Policy to identify who can be dismissed and when
- A "progression review" policy to regulate when trainees are reviewed to determine their position in the SET continuum, and its effect on their post allocation (if any)
- Identification of "normal progress" – that is, standards for each identified level of training within the training program.
- Guidelines on how interruption and research fits into a more flexible program. That is, is it acceptable for someone who is identified as a slow learner to take 7 years to undertake clinical rotations plus interrupt for 2 years and do 2 years of research, thereby taking 11 years between commencement and attaining the fellowship?
- Review of the impact of variable paced learning on post availability and therefore selection. If some trainees occupy training posts for longer periods will this reduce through-put and opportunities for new trainees.

Issues relating to trainees

Trainee numbers

The College's Interim Activity Report, for the period January to April 2010, records a total of 1221 active surgical trainees across Australia and New Zealand. Of these 202 are based in New Zealand (as of 31 October 2010). The number of active trainees, by specialty and by SET year, is detailed in Tables 8&9 in Appendix 3. This does not includes trainee who have deferred beginning their training or trainees who have interrupted their clinical training for any reason (research, ill-health, family reasons, etc).

Trainees awarded Fellowships

After successfully completing all of the requirements of the training program, trainees are awarded a Fellowship. In recent years the number Fellowship awarded annually by the College has fluctuated, although consistently being over 200 annually (see Tables 11-15 in Appendix 3). Of these, between 2007-2009 inc a total of 89 were New Zealand based trainees.

RACSTA

The College Trainees Association (RACSTA) has now been running for almost 5 years. RACSTA has an independent board structure within the College, including an executive body. RACSTA representatives are now established in all specialties, all Australian states and New Zealand, where they represent trainees on College Training and Regional boards (states and NZ).

In addition to these representations, members of the RACSTA executive group hold positions on all central College Boards relevant to training: principally the Board of Surgical Education and Training, and Education Board. RACSTA reports officially to Education Board, and has a close working relationship with the RACS Censor in Chief. RACSTA routinely participates in College workshops and discussions.

As of this year, the RACSTA Chair has also been constitutionally voted as a co-opted member of the College Council. This significant step means that trainees are now represented at the highest governance level within the College. Adequate support is provided for the trainee chair in fulfilling this significant responsibility.

A primary role of RACSTA is to inform trainees of the activities of decision-making committees, and to communicate trainee opinion back to these committees. Information distribution is primarily the responsibility the RACSTA specialty and regional representatives but is also carried by RACS and RACSTA via the College website and in College publications (email bulletins, Surgical News, the ANZ Journal of Surgery, regional newsletters and information booklets).

RACSTA has initiated a new conference, starting in 2010, to inform newly inducted SET trainees about the requirements and regulations of SET, and the functions of the College.

Significant issues presently being raised by RACSTA with the College include:

i) *Improved orientation procedures* for new trainees. Some trainees have struggled with understanding the requirements of the SET program. As above, a new induction conference is therefore planned to resolve this.

ii) *Trainee term feedback of terms*. RACSTA has developed an on-line trainee term feedback tool, and it has been approved that this form (or a close variant of it) will be implemented in each of the specialties within the next 12 months. This tool provides trainees the opportunity to provide feedback about their supervision and training experiences in a supportive manner. Results will be audited by the training boards or training supervisors, by RACSTA and by the College Education and Research Division.

iii) *Working hours*: RACSTA has completed a major survey of trainee working hours and preferences / attitudes to working hours. The response rate was >55%. A peer-reviewed publication has been accepted for the ANZ Journal of Surgery and a second article is under preparation. Further work is being done to develop a trainee position statement on trainee working hours. The College has been supportive of trainee interest in this issue.

iv) *Flexible training*: RACSTA has been working with RACS to improve access to flexible training. There is significant unmet demand, especially amongst female trainees. RACS has robust policies to support flexible training, but it is not easy for trainees to find accommodating training positions in the jurisdictions. RACSTA is piloting job-share matching systems, is investigating whether part-time training positions can be established, and is evaluating the barriers currently existing to flexible training at the jurisdictions.

Progress on these initiatives is regularly reported by RACSTA representative to the College education committees where their work receives strong support.

Supervisors

The support of the surgical supervisors is central to the clinical program. All hospitals with accredited specialist surgical training programs have hospital supervisors of surgical training and specialty supervisors of training approved by the College, and these Fellows of the College oversee the trainee's clinical development.

As outlined above (in managing under-performing trainees) the College now provides training for its training supervisors and surgical trainers through its courses. The learning outcomes of these courses are to:

a) be aware of the College's expectations of supervisors and trainers
b) understand how to use work-place-based assessment tools to assess a range of competencies
c) identify trainees who are underperforming and possible reasons for that underperformance
d) manage the trainee who underperforming to either improve and meet the required standards, or be dismissed, and
e) to understand the College's training policies and legal issues relating to supervision.

The College strongly supports the development of improved communication between the surgical training boards and the supervisors and trainers. This is being done in two ways. One is through improved information provided to the supervisors and trainers. The other is to monitor the opinions of the supervisors and trainers about the program and to systematically seek feedback.

Some of the specialty training boards have introduced processes to ensure that their supervisors are well informed about their roles and responsibilities.

- Neurosurgery, Orthopaedic Surgery and Urology training boards have all arranged for SAT SET course to be provided at their Annual Scientific Meetings
- In Neurosurgery the board:
  - continues to write to supervisors when changes are made to the SET Program in Neurosurgery Handbook and includes a section in the NSA newsletter highlighting changes
  - Updates the SET Program in Neurosurgery Handbook regularly. This handbook contains all information relevant to supervisors, trainees and training institutions.
- The board of Paediatric Surgery requires all their supervisors and trainers to complete the SAT SET courses
- The Urology board:
  - is developing more extensive documentation to provide supervisors and trainers regarding the diligence and expertise required in identifying poor performance.
  - Plans to hold an education forum at the USANZ ASM in 2011

In 2010, as part of its review or SET, the College conducted an extensive survey of all supervisors and trainers. Some specialties have also instituted monitoring processes, For example, this year:

- General Surgery has developed a survey to gauge the response of supervisors and trainees when implementing / considering implementing changes. Opinions were sought from supervisors on changes to formative assessments, and the possible introduction of an online trainee forum (to be used for study groups, information sessions, supervisor / trainee conversation / tutorial sessions)
- The Urology board is in the process of conducting a survey of trainers and supervisors about their opinions and feedback regarding the SET program.

Training posts

In 2005, following an extensive review of the accreditation process by the ACCC the College developed generic accreditation criteria to be used by all surgical specialties.

The underlying principle of the accreditation process is to ensure that hospitals and training posts provide learning environments which facilitate the training of safe and competent surgeons. The College, with the help of its boards, the various specialty associations/societies and the jurisdictions, has developed a hospital accreditation process and set of accreditation criteria. The criteria are based around seven core educational, clinical and governance standards required to provide training in a range of clinical contexts. The standards and criteria have been produced to enable trainees acquire the competencies and fulfil the roles identified as necessary by the College.

The process of accreditation may be initiated by a hospital which wishes to undertake surgical training for the first time, or by the College where re-accreditation needs to occur at the completion of a previous period of accreditation. Normally hospitals are accredited, or re-accredited for a period of five years.

The criteria for accreditation are available on-line for hospitals to carry out a self assessment which they could provide the Specialty accreditation team prior to the inspection.

In the latter part of 2006 the accreditation criteria were reviewed and the revised criteria were published early in 2007.

Posts are only accredited when they are recognised as being able to offer appropriate training opportunities including case load, case mix and supervision.

The specialty training boards monitor the quality and outcomes of training in each post for SET. They do this through their regular hospital accreditation processes and also through information drawn from trainees' logbooks and trainees' evaluation information.

Since 2007 some surgical specialties have decided to provide additional detailed criteria

- The Urology board, which works with the board of General Surgery in the training of their SET1&2 trainees has developed a Urology specific accreditation documentation for SET1 and SET2 posts. This documentation complements the pre-existing accreditation material for SET3-SET6 posts.
- Paediatric Surgery has introduced detailed accreditation evaluation reports including access to outpatient and ambulatory experience
- The OHNS Board has insisted on trainees having access to at least 2 supervised teaching outpatient clinics every week. There is a requirement that trainees have regular opportunities to assess new patient presentations in these clinics. Trainees have been directed to fill out

performance reports on rotations which are not felt to be up to standard and have been placed on probation.

Potential changes to posts numbers

The College is cognisant of the population growth, and the ageing of the population, in both New Zealand and Australia. It has recognised the need to increase the number of surgical graduates in order to maintain even the current level of surgical services. Specialty boards and the College continue to seek opportunities to increase the number of training posts.

Public hospitals have been encouraged to apply for recognition of registrar positions as accredited training posts. However, increasing the number of trainees in an apprenticeship training program requires either increased access to patients or an extension of training years. The latter is not the College preferred approach. Therefore there are a number of interrelated issues that led to the College holding meetings in Australia and New Zealand in August this year to discuss possible ways for trainees to gain access to training in private posts. These issues include:

- Funding in both the Australian and New Zealand public health systems is unlikely to increase surgical patient numbers sufficiently to increase training numbers
- The difference in the case-mix between the public and private sectors i.e. a high percentage of acute cases in public hospitals, compared with a high percentage of elective cases in private hospitals. This imbalance means that:-
- Trainees in public hospitals no-longer get access to training in many of the procedures which they will be required to perform as a Fellow.

Proposals on training in the private sector have been put to the Minister of Health and discussed with Health Workforce New Zealand. This may result in some changes to how surgical training is delivered.

C. CULTURAL COMPETENCE

Cultural competence is awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds.

Of the nine competencies which form the framework for surgical training and Fellowship performance, cultural competence has not been identified as a separate competence. Rather it has been deliberately incorporated within several of the professional (non-technical) competencies which impact on relationships between people for example, Communication, Health Advocacy, and Professionalism and Ethics.

As such, cultural competence is assessed at all stages of the training program, and is strongly advocated through the College's approach to professional development. For example:

- Trainees' assessment forms require that supervisors and trainers comment on a trainee's communication skills in each 3 monthly assessment process and report to the specialty training board at the end of each 6 monthly assessment. If a trainee is considered to be deficient in this area, their supervisors and trainers consider mechanisms that will assist the trainee to improve his / her skills.
- The College has published a guide to "Surgical Competence and Performance" that presents a framework for assessing the performance of practising surgeons in the nine defined College competencies. This identifies behavioural markers of good and poor performance. While not considered to be an exhaustive list these markers are examples of 'good' and 'bad' behaviour in key areas. The section on communication competency specifically refers to awareness and sensitivity to different cultural backgrounds as an important behavioural marker of effective communication.
- The College runs a number of Professional Development courses for surgeons and trainees. These include several that are designed to assist with and improve communications skills and cultural awareness. Attendance at such courses is encouraged through the award of points for Fellows' Continuing Professional Development (CPD) requirements. Course provided by external bodies (eg. cross cultural courses, Treaty of Waitangi courses) may also be eligible for CPD points.
- The College does not specify use of the MCNZ statements on cultural competence and on best practices when providing care for Māori patients and their whānau. However, there is awareness that these exist and Fellows and trainees are referred to them when issues of cultural competence arise.
- Equally the College currently does not specifically focus on cultural competence in relation to Aboriginal or Torres Strait Islanders, nor on any of the many other cultures represented in the general population, patient population, and workforce, in both Australia and New Zealand.

In the next twelve months, with the development of the new College website and a revision and enhancement of the training resources relating to the professional competencies, it is intended that additional information on all of these different cultural areas will be included. For example:

- Links to the material on a range of websites including MCNZ; CPMC; NHMRC and DHI.
- The Otolaryngology Head and Neck Surgery training board is currently working with the College to write a curriculum for indigenous health for Australia and New Zealand.

Cultural competence is an issue under consideration by the College Indigenous Health Committee, which includes a representative from the Te Ora Board.

D. RECERTIFICATION PROGRAM

Across the nine surgical specialties the College has a total of Active 5430 Fellows of whom 698 are based in New Zealand (see Table 17, Appendix 3).

A copy of the CPD program will be sent with the mailed copy of this submission. Information about the College CPD program is also available on-line at:
http://www.surgeons.org/media/6982/CPD_Info_Manual_2010-2012.pdf

Continuing Professional Development (CPD)

All active Fellows of the College are required to participate in the CPD Program. The program aims to:

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

There has been only one change of note to the CPD Program for 2010. This is a requirement to participate in the Australia and New Zealand Audit of Surgical Mortality as it becomes available in the various jurisdictions. The CPD program is recorded in a credit point system (rather than hours) to enable weighting for educational value and continues to have an emphasis on active learning, recognising the value of activities such as peer review of practice; surgical/clinical attachments; patient feedback surveys; interactive workshops/small group learning activities and learning and development plans.

Surgeons are responsible for maintaining their skills, knowledge and competence and for keeping up-to-date with developments in their area of practice, as well as developments in clinical and medical science. These requirements can be met by attendance at scientific meetings and workshops/seminars directed at maintaining and enhancing knowledge and skills and other self directed learning. Maintenance of knowledge and skills can also be achieved through teaching, research and publication activities.

For those surgeons who are vocationally registered in Australia and New Zealand, and who are not Fellows of the College, the Department of Professional Standards also offers the Maintenance of Professional Standards (MOPS) Program. This is very similar to the CPD program for College Fellows; the key difference is that MOPS has an annual cycle while the CPD program runs to a triennium cycle, but with a number of annual requirements within it. IMGs who are vocationally registered in New Zealand in one of the nine surgical specialties of this College are automatically approved to enrol in the MOPS program.

As part of the College's continued commitment to providing transparency to our CPD processes, Fellows are reminded to maintain records of their CPD for verification purposes. Fellows who are selected for verification are notified in writing and are required to submit verification data for the previous year. The percentage of Fellows selected for verification has increased slightly with effect from 2010.

Actions taken to improve participation in the CPD Program:

- Introduction of data collection through CPD Online enabling real time recording of CPD activities.
- Publication and distribution of the Guide to Surgical Competence and Performance (2008) to all Fellows to assist in self reflection on professional development needs.
- Publication and distribution of the Surgical Audit and Peer Review Guide (revised 2008) to all Fellows and trainees to strengthen support for auditing activities.
- Increased contact with Fellows who are non-compliant or non-participant by Specialist Society representatives on the Professional Development and Standards Board. Representatives provide follow up and assistance to individual members of their Society.
- Structured administrative processes as part of the annual cycle, including two reminder letters and a letter from the College President to Fellows who are slow to participate/comply.

Self-regulation and recertification

- Since 2000, Council has determined that it is mandatory for all Fellows in active practice to participate in an approved CPD Program.

- Issue of the 2007–2009 CPD Program Certificate is evidence of recertification as a Fellow of the College and is valid until December 2012 (conclusion of the current triennium).
- In order to maintain accountability and transparency with respect to the CPD Program, 3.5% of Fellows with a requirement are randomly selected to verify their annual CPD activities. Fellows who fail to verify their CPD activities are not eligible for the annual statement of participation or the triennial certificate.

Participation rates in the CPD (Recertification) Program

Participation rates in the CPD (Recertification) Program remain high. Data collection for 2007-2009 triennium is shown in Table 17, Appendix 3. 3517 Fellows had a requirement to participate in the RACS CPD Program. In New Zealand in 2007 99% met the requirements and in 2008 97% met the requirements. The finalised 2009 data will be available in the 2010 End of Year Activities Report.
Notes:

1. CPD data is collected retrospectively (if submitted in hard copy) and exemptions are given to Fellows for reasons of leave, full time study etc.
2. the statistics from Orthopaedic Surgery do not include the surgeons in that discipline who submit their details through the Orthopaedic Associations in Australia or New Zealand.

Measures to address non-participation

The College has formulated regulatory measures to address non-participation, within the framework of AMC/CPMC initiatives and MCNZ requirements

When a Fellow is found to not be meeting the CPD requirements or is non compliant with the requirements, they receive three reminder letters from the College throughout the year. In addition their names are given to the relevant specialty society representative on the Professional Development and Standards Board who send them follow up letters in June and October. In November they are sent a final reminder letter from the President.

Fellows who do not participate in the Program (and comply) are ineligible to be listed on the publicly available 'Find a Surgeon' list on the College website.

Unlike some other Colleges, RACS does not take any further action, such as terminating Fellowship or suspend/terminate Fellowship until the CPD requirements are met.

The Professional Development and Standards Board continues to deliberate on incentives and sanctions to increase participation and full compliance in the CPD Program.

Poorly performing colleagues

The College employs a surgeon in the part time position of Executive Director for Surgical Affairs (EDSA) in both Australia and New Zealand. The responsibilities of those roles include providing assistance for Fellows who may have some level of concern about a colleague's practice but are unsure how to progress the issues.

In 2009 the College Council approved a process for handling potential breaches of the College's Code of Conduct. When a complaint about a Fellow is received by the College (this may come from a range of sources such as a patient, a colleague, or an employer) or information of poor performance is obtained via a statutory process (such as the Health Practitioner's Disciplinary Tribunal or the Health & Disability Commissioner) this is reviewed within the College by the CEO and the EDSA. If the complaint involves a serious allegation of misconduct, and particularly if patient safety is at risk, it will be referred to the relevant medical registration authority. Otherwise, it is reviewed internally, the Fellow given the opportunity to comment (if the issue has not already been through an accepted investigation process) and, if it is determined that the Code has been breached, the Fellow will be required to sign a statutory declaration. That declaration indicates that the Fellow acknowledges and will abide by that Code and that s/he is aware that a further breach may result in their fellowship being rescinded.

Some of the components of CPD

Audits and peer review

Requirement for peer reviewed clinical practice audits continue to be important components of the CPD program, and is an annual requirement for all Fellows in operative practice. It is through the comparison of outcome data with the performance data from colleagues, other institutions and clinical literature that practice improvement opportunities can be recognised, both at an individual and systemic level.

An increasing number of Fellows contribute to bi-national morbidity audits that focus on a subspecialty / subsection within a specialty (eg. breast cancer audit; audit of endovascular repair; colorectal cancer audit). Some of these are managed through the College and others by the relevant specialist surgical society (for example, the incontinence sling audit managed by the Urological Society of Australia and New Zealand; the National Joint Registry managed by the NZ Orthopaedic Association; and the Australian and New Zealand Society for Vascular Surgery's Binational Audit).

The College requires that all Fellows participate in audits of Surgical Mortality, where these exist. It is regrettable that New Zealand is the only geographic region in the College that does not yet have a surgical mortality audit in place. There has been regularly lobbying of statutory agencies and Ministers by this College and by the Anaesthetic College for such a system and the current Government has recently given its support for the establishment of a peri operative mortality audit in New Zealand. The College looks forward to such a system being in place, hopefully within the next 12 months. The existing mortality audits review all deaths associated with surgical practice and seek to identify any surgical practices – both accepted practices and outlying practices - that may have contributed or resulted in the most severe poor outcome (death). When accepted practices have been used, mortality audits are able to gather data across a wider than normal spectrum to inform changes in knowledge and its application. When a practitioner's performance is identified as an "outlier" this can be identified by the audit and information discussed with the practitioner. If the New Zealand system follows those that exist already in Australia, there will be follow up with individual performance 'outliers'.

Practice Visits

The College is aware that the MCNZ is interested in having practice visits become a compulsory element of approved CPD program. It is understood that this is considered as an improved mechanism to identify "poor performers". The College is comfortable with practice visits being an optional component of CPD but does not consider that the resources that would be required for compulsory visits (and the associated opportunity cost of less clinical service delivery) is justified by any validated research. We are aware that the NZ Orthopaedic Association is currently undertaking a trial of such visits to a group of self nominating practitioners and look forward to reviewing the report that will come from this trial.

Supervision, teaching and examinations

Teaching in RACS courses, supervision of trainees, writing educational materials; teaching trainees, undergraduate medical students etc., and serving as an examiner for the College or other recognised educational institution are all recognised as important components of CPD.

Workshops and courses

Although the courses offered by the College vary from year to year there is always a cross section of courses providing training in each of the professional competencies. The courses listed below are examples of those which were offered in 2010.

Standards for accreditation of educational activities for CPD points have been in place since 2002 and the application process around endorsement of these activities is frequently reviewed and promoted to the Fellowship. Participation in workshops is a popular form of accruing CPD points.

Whole of College surveys are carried out to appraise professional development needs. For instance the 2006 survey identified 'risk management' and 'governance' as two areas where Fellows wanted more professional development. As a result, additional communication courses and one workshop focussing on the roles and responsibilities of committee and board members were offered. A further survey is being carried out in 2010.

Before each course a needs analysis is sent to course registrants to determine individual requirements and expectations. A report is then sent to the facilitator, which is particularly important if registrations are low to ensure that participant needs are being met. The report is also used to ascertain whether promotional information is clear and accurate. The survey results can also be used to redesign courses or to design additional modules to complement a course.

Courses and programs with a main focus on Professionalism, Communication and Collaboration

Writing Reports for Court

The Writing Reports for Court half-day workshop offers skills based training in drafting medical reports for use in legal matters and is offered in conjunction with Leo Cussens Institute. Participants are involved in a wide range of practical examples in a small group setting.

Participants are required to complete and submit a report based on a standard case study prior to the workshop. This case study is then provided to the legal and surgical instructors, who provide feedback during the course of the workshop. Participants from all specialties are encouraged to attend and are provided with supporting material to assist with the medical components of the case study.

Courses and programs with a main focus on Scholar / Teacher

Surgical Teachers Course

This two and a half day workshop aims to enhance the educational skills of surgeons responsible for teaching, mentoring and assessment of trainees and others.

The workshop consists of four major modules:

1. Adult Learning: educational framework, goals and objectives, principles of adult learning, questioning techniques.
2. Teaching Skills: presentation planning and structure, presentation skills, teaching and learning in the OR/ambulatory setting/ bedside setting.
3. Feedback and Assessment: methods of feedback and giving effective feedback, principles of measurement, methods of testing, methods of technical skills assessment, professional behaviour assessment, assessing marginal trainees.
4. Leadership and Change: plans for change, change processes, obstacles to change, leadership and leadership styles, conflict resolution.

Those involved with teaching of trainees as well as final year College trainees are the core audience for the workshop. The faculty is sourced from graduates of the Surgical Teachers Course; led by one or more members of the Surgeons as Educators Committee.

SAT SET

This three hour workshop provides an opportunity for supervisors of surgical trainees to enhance their feedback and formative assessment skills using DOPS and Mini-CEX. It explores the effective use of the new evaluation tools, provides practical insight into supporting and assessing trainees as well as outlining associated College policies, procedures and legal processes.

Over 1500 Fellows have attended a SAT SET Course since it was launched in May 2007. This number includes more than half of all supervisors of training (see table below, data as at June 2009). There continues to be strong demand for the SAT SET course. Most of the courses are delivered at capacity –with 25 courses offered in 2010, and ~20 in 2011.

Courses and programs with a main focus on Professionalism

Beating Burnout

This new half day workshop identifies the symptoms of burnout and discusses the particular mental health issues that surgeons are at risk of suffering if they cannot achieve adequate balance between their work and personal lives. Recognising the competing priorities surgeons face and the challenge of patients' and society's view that surgeons should always be ‘on call’, this workshops offers advice and practical strategies to work towards work/ life balance.

On completion of this workshop participants will have learnt to recognise the symptoms in themselves and others as well as practical strategies and tips that will help to stay balanced and in control. Through exercises, lectures and small group discussion, participants will come away with a better understanding of how to beat burnout by developing an achievable plan to begin implementing changes important to their lives.

Building towards retirement

The Building Towards Retirement workshop is a whole day program developed in response to Fellows’ requests for advice on planning for retirement and on alternative lifestyles after ceasing full time surgical practice. Each workshop is convened by College Fellows with an interest and expertise in the area of retirement from surgical practice. Topics covered include legal requirements of selling or winding down a practice, lifestyle changes, financial planning and superannuation advice.

Courses and programs with a main focus on Management and Leadership

Practice Made Perfect: Successful Principles in Practice Management

This Practice Management course is a one day workshop specifically developed for managers of surgical practices. A leading practice management consultant presents an overview of the role of the

practice manager and addresses other topics such as business planning, human resources and staff recruitment, practice systems, customer service, and medico-legal issues.

Leadership in a Climate of Change

This two-and-a-half day workshop is designed to assist participants understand what it takes to be an effective leader in this century, to learn more about working as a team and gaining team commitment. These issues will be discussed in the context of organisational change and management. It uses the DISC model (DISC stands for dominance, influence, steadiness and conscientiousness) to examine the nature and practice of organisational leadership, through the exploration of issues such as organisational communication; influence; power; styles of leadership.

Sustaining your Business

This two-and-a-half day workshop provides the foundation for developing business plans and various approaches to their implementation to sustain business growth and performance. It explores financial management, from the preparation and analysis of responsible budgetary plans, decision making, management and reporting, to the development of estimates and capital investment proposals and addresses both perspectives of health practice management and the broader health service delivery environment.

Courses and programs with a main focus on Management and Leadership, and Professionalism

Younger Fellows Forum

The YFF is an annual two and a half day retreat drawing Younger Fellows together to discuss and debate issues relevant to their particular cohort of the College. The objectives of the forum may be described as follows:

- to provide an environment that allows for and encourages Fellows to face challenging issues relevant to personal, professional and Collegiate life by sharing ideas and experiences, discussions and debates
- to reflect on personal and professional development
- to experience a sense of fellowship
- to understand the structure and function of the College
- to encourage the involvement of Fellows in the College
- to provide the opportunity for Fellows to have a voice in the College
- to provide the opportunity for Fellows to influence the College in its processes
- To simply enjoy oneself and the company of Fellows.

The YFF offers a unique opportunity for a diverse and representative group of Fellows to gather and share ideas and experiences and to discuss and debate issues that they believe affect their professional and personal lives. It provides Fellows with an insight into the workings of the College. It fosters a generous sense of fellowship and friendship across surgical disciplines. It kindles the will amongst Fellows to make changes that count in personal and professional development. Above all, the YFF empowers Fellows to influence the College, either as individuals or collectively, in the way the College serves its Fellowship and the community.

Courses and programs with a main focus on Collaboration and Professionalism

From the Flight Deck: Improving Team Performance

This new two day interactive workshop is an opportunity for surgeons to learn how the aviation industry has approached the issue of errors. 70% of aviation accidents have some human error contribution. Crew Resource Management (CRM) training involves developing an understanding of various issues such as personality, communication, leadership and team dynamics. Participants will be able to experience managing an emergency in a flight simulator and transfer this learning to their working environment through case studies.

Courses and programs — main focus on Communication

Communication Skills for Cancer Clinicians

Communication Skills for Cancer Clinicians workshops are offered in Victoria in conjunction with the Victorian Cancer Council. The workshop was first introduced in 2004, and is available to relevant medical practitioners as well as Fellows and trainees of the College. The half day workshop is facilitated by a cancer clinician and a clinical psychologist and aims to provide participants with

evidence based communication skills to assist in delivering bad news to cancer patients and their families.

Mastering Difficult Clinical Interactions

This full day Master class helps surgeons to understand the underlying causes of difficult clinical interactions and to develop strategies to strengthen the surgeon/ patient relationship.
The morning presentation focuses on causes of difficult clinical interactions and ways to understand patient motivations and reactions. Presenters also focus on skills and techniques to manage these types of difficult interactions focusing on interpersonal skills, communicating empathy and enhancing effectiveness and ease in dealing with challenging clinical situations.
The afternoon session gives participants the opportunity to put their new skills into practise in simulated consultations with trained actors. Each participant will have the opportunity to participate in role playing activities and gain valuable feedback from the presenters and their peers. This workshop is delivered in partnership with the Cognitive Institute.

Polishing Presentation Skills

This is a new one-day workshop for Fellows who want to improve their oral presentation skills. The workshop covers presenting clinical information in various settings; from information and teaching sessions in hospitals or the College, to conferences and major medical congresses.

Understanding Your Patients

This one day workshop is designed to provide surgeons with an insight into a range of cultural value systems, different intercultural communication styles and to help develop strategies to effectively communicate with people from different cultural backgrounds.

Interviewer Training

This two hour workshop is designed specifically for Fellows who are conducting interviews for trainee selection into Specialties. It incorporates practise in interview questions and techniques. Video-conferencing will be used to deliver the workshop to Interviewers in other capital and large regional centres. Fellows are required to participate as new interviewers then as a refresher after two years.

E. SPECIAL INTEREST GROUPS

The College supports the interests of Fellows, and of the community, through a range of interest groups and sections. These include those listed below:

- Younger Fellows (ie. Fellows within 10 years of the award of Fellowship)
- Trauma
- Rural Services
- Indigenous Health
- Women in Surgery
- Senior Surgeons
- Surgeons as Educators
- Medico-legal Section
- Military Section

Surgical Sections

- Breast Surgery
- Transplant Surgery
- Upper Gastrointestinal and Hepato-Pancreato-Biliary Surgery
- Colon and Rectal Surgery
- Endocrine Surgery
- Surgical Oncology

A number of these interest groups and sections are led by Committees; and the terms of reference can be provided to the MCNZ, on request.

F. GENERAL COMMENTS

In 2010 the College is revising its 'Code of Conduct'.

The Code has been developed to recognise that, in addition to medical knowledge and technical expertise, excellent surgical care requires collaboration with colleagues and other health professionals, co-operation with management and participation in teaching and mentoring. Appropriate conduct in research and business practices is also expected. The Code requires that surgeons blend objectivity with compassion, accepting that patients' interests are primary, and that their dignity, individuality and autonomy are always to be respected in a culturally and socially sensitive manner.

The current Code of Conduct is accessible on-line at:
http://www.surgeons.org/media/8245/FES_PST_2021_P_Code_of_Conduct.pdf

APPENDICES

Appendix 1: List of Acronyms

Appendix 2: Diagrams of College governance and administrative structures

Appendix 3: Training, Fellowship and CPD Statistics

Appendix 1

List of Acronyms

ASSET	Australian and New Zealand Surgical Skills Education and Training (course)
ASSH	Australian Society of Simulation in Healthcare
BST	Basic Surgical Training
BSET	Board of Surgical Education and Training
CPD	Continuing Professional Development
COAG	Council of Australian Governments
EB	Education Board
ESC	English-Speaking Countries
FEX	Fellowship Examination
FRACS	Fellow of the Royal Australasian College of Surgeons
GSA	General Surgeons Australia
HWNZ	Health Workforce New Zealand
HWPC	Health Workforce Principal Committee
IMG	International Medical Graduate
KTOT	Keeping Trainees on Track
NHWT	National Health Workforce Taskforce
NZAGS	New Zealand Association of General Surgeons
PDSB	Professional Development and Standards Board
PFET	Post Fellowship Education and Training
RACS	Royal Australasian College of Surgeons
RACSTA	Royal Australasian College of Surgeons Trainee Association
SAT SET	Supervisors and Trainers for SET (course)
SET	Surgical Education and Training
SSE	Surgical Science Examination

Surgical Specialties

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

Appendix 2: Plan of College Governance Structure

Plan of College Administrative Structure

Appendix 3: Training, Fellowship and CPD Statistics

Table 2: Statistical Tables

	Statistics	Table(s)	Page(s)
a.	The number of applicants to the training programs and trainees entering each surgical specialty training program	3-7	32-34
b.	The number of trainees undertaking each surgical specialty training program	8-9	35-37
c.	College trainees in New Zealand by specialty and training level	10	38
d.	New Fellows by Specialty and location 2002 – 2010	11-15	39-
e.	New Zealand Fellows summarised by admission year and specialty	16	
f.	The number and proportion of College Fellows participating in the College's continuing professional development programs by specialty and location		

Table 3: 2007 SET Applications by Specialty and Location

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUST	NZ	O/S	Total
Cardiothoracic	0	15	0	8	1	1	21	7	**53**	9	0	**62**
General Surgery	8	140	1	79	20	4	121	28	**401**	71	4	**476**
Neurosurgery	3	26	0	18	2	1	22	6	**78**	9	0	**87**
Orthopaedic	1	53	1	21	7	1	46	12	**142**	18	3	**163**
Otolaryngology Head & Neck	6	69	2	41	14	4	54	18	**208**	49	3	**260**
Paediatric	2	8	0	6	0	0	7	4	**27**	4	0	**31**
Plastic & Reconstructive	2	60	0	26	13	4	65	19	**189**	26	1	**216**
Urology	1	39	0	27	5	0	46	9	**127**	29	2	**158**
Vascular Surgery	1	32	0	12	2	0	18	7	**72**	12	0	**84**
Total	**24**	**442**	**4**	**238**	**64**	**15**	**400**	**110**	**1297**	**227**	**13**	**1537**

Note:

1. The numbers of applicants in 2007 was approximately twice the number in subsequent years because this represented selection into SET2 (previously SST1), as well as selection into SET1
2. Note: the numbers in Tables 3-6 (inc) include applicants who submitted applications to more than one specialty

Table 4: 2008 SET Applications by Specialty and Location

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	AUST	NZ	O/S	Total
Cardiothoracic	0	13	0	6	0	0	11	4	**34**	5	0	**39**
General Surgery	4	95	1	53	10	5	65	11	**244**	45	2	**291**
Neurosurgery	1	21	0	8	1	1	9	2	**43**	5	1	**49**
Orthopaedic	2	39	0	17	7	2	28	5	**100**	13	0	**113**
Otolaryngology Head & Neck	4	55	1	34	16	4	43	14	**171**	31	0	**202**
Paediatric	0	13	0	4	0	0	3	1	**21**	3	1	**25**
Plastic & Reconstructive	2	33	1	18	8	5	50	12	**129**	15	0	**144**
Urology	1	26	1	19	5	2	30	9	**93**	12	0	**105**
Vascular Surgery	1	20	0	7	1	0	9	5	**43**	6	0	**49**
Total	**15**	**315**	**4**	**166**	**48**	**19**	**248**	**63**	**878**	**135**	**4**	**1017**

Table 5: 2009 SET Applications by Specialty and Location

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	**AUS**	NZ	O/S	**Total**
Cardiothoracic	0	11	0	5	1	0	12	3	**32**	9	0	**41**
General Surgery	5	104	2	63	14	4	82	18	**292**	47	0	**339**
Neurosurgery	1	23	0	7	3	3	17	5	**59**	7	0	**66**
Orthopaedic	4	51	0	45	18	3	49	13	**183**	32	0	**215**
Otolaryngology Head & Neck	1	33	0	26	8	2	25	6	**101**	15	0	**116**
Paediatric	0	9	0	4	2	0	3	2	**20**	5	1	**26**
Plastic & Reconstructive	1	39	0	20	5	4	37	6	**112**	16	0	**128**
Urology	0	29	0	26	6	2	30	6	**99**	15	0	**114**
Vascular Surgery	0	20	0	11	5	0	11	7	**54**	9	0	**63**
Total	**12**	**319**	**2**	**207**	**62**	**18**	**266**	**66**	**952**	**155**	**1**	**1108**

Table 6: 2010 SET Applications by Specialty and Location

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	**AUS**	NZ	O/S	**Total**
Cardiothoracic	1	6	0	3	1	0	9	3	**23**	8	0	**31**
General Surgery	8	107	8	64	22	6	110	20	**345**	53	1	**399**
Neurosurgery	2	23	0	11	2	1	23	3	**65**	2	1	**68**
Orthopaedic	3	60	0	37	17	1	52	15	**185**	36	0	**221**
Otolaryngology Head & Neck	1	32	2	21	5	4	32	6	**103**	8	0	**111**
Paediatric	2	9	1	4	2	0	4	2	**24**	3	1	**28**
Plastic & Reconstructive	3	38	0	9	5	1	41	5	**102**	12	0	**114**
Urology	2	27	2	20	4	4	24	9	**92**	17	0	**109**
Vascular Surgery	3	15	1	7	2	0	9	6	**43**	8	0	**51**
Total	**25**	**317**	**14**	**176**	**60**	**17**	**304**	**69**	**982**	**147**	**3**	**1132**

Table 7: 2007 - 2010 SET Accepted Offers by Specialty

	2007	2008	2009	2010
Cardiothoracic Surgery	8	8	3	11
General Surgery - Aus	226	92	104	114
General Surgery - NZ	28	21	20	16
Neurosurgery	23	11	14	12
Otolaryngology Head and Neck Surgery - Aus	30	22	14	6
Otolaryngology Head and Neck Surgery - NZ	6	4	6	3
Orthopaedic Surgery - Aus	65	60	49	49
Orthopaedic Surgery - NZ	12	18	13	11
Paediatric Surgery	5	8	6	9
Plastic and Reconstructive Surgery - Aus	30	10	18	18
Plastic and Reconstructive Surgery - NZ	5	6	6	2
Urology	53	26	24	26
Vascular Surgery	16	16	12	8
Total	**507**	**302**	**289**	**285**

Notes:

1. The numbers of accepted offers in 2007 (to commence training in 2008) was approximately twice the number of subsequent years because this represented selection into SET2 (previously SST1), as well as selection into SET1
2. The number of available posts in each specialty varies from year to year because of:
   - The number of trainees completing their training
   - The number of accredited posts available (this can be increased with the identification of new posts, or decreased with the disaccreditation of posts)
3. The 2010 acceptance figures do not include potential second and third round offers for General Surgery (Australia)
4. For 2010, the number of available posts in Otolaryngology Head and Neck Surgery in Australia is smaller than usual because of the transition from first year training in General Surgery.

Table 8: 2009 Total SET Trainees by Specialty and Status

Status		Gender	CAR	GEN	NEU	ORT	OTO	PAE	PLA	URO	VAS	Total
Active	Clinical	Male	29	295	26	254	51	13	61	90	40	**859**
		Female	4	130	8	17	39	12	24	24	12	**270**
		Total	**33**	**425**	**34**	**271**	**90**	**25**	**85**	**114**	**52**	**1129**
	Accredited Research	Male	3	2	13	0	3	0	2	4	0	**27**
		Female	1	2	3	0	0	0	0	0	0	**6**
		Total	**4**	**4**	**16**	**0**	**3**	**0**	**2**	**4**	**0**	**33**
	Part Time	Male	0	0	0	0	0	0	0	0	0	**0**
		Female	0	1	0	0	0	0	0	0	0	**1**
		Total	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
	Probationary	Male	1	13	2	0	0	0	0	1	0	**17**
		Female	0	2	0	0	0	0	0	0	0	**2**
		Total	**1**	**15**	**2**	**0**	**0**	**0**	**0**	**1**	**0**	**19**
	Exam Pending	Male	3	3	0	2	0	0	0	0	0	**8**
		Female	0	0	0	0	0	0	0	0	0	**0**
		Total	**3**	**3**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**8**
Inactive	Approved Interruption to training	Male	1	16	3	0	4	0	2	4	1	**31**
		Female	0	14	2	1	3	1	1	1	0	**23**
		Total	**1**	**30**	**5**	**1**	**7**	**1**	**3**	**5**	**1**	**54**
	Deferred	Male	0	4	0	0	2	0	0	3	2	**11**
		Female	0	1	0	0	0	0	1	1	0	**3**
		Total	**0**	**5**	**0**	**0**	**2**	**0**	**1**	**4**	**2**	**14**
	Suspended	Male	0	0	0	0	0	0	0	1	0	**1**
		Female	0	0	0	0	0	0	0	0	0	**0**
		Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**
Left Program	Terminated	Male	0	4	1	1	0	0	0	1	0	**7**
		Female	0	1	0	0	0	0	0	0	0	**1**
		Total	**0**	**5**	**1**	**1**	**0**	**0**	**0**	**1**	**0**	**8**
	Withdrawn	Male	0	16	3	0	2	0	3	1	1	**26**
		Female	0	20	0	0	3	2	0	0	0	**25**
		Total	**0**	**36**	**3**	**0**	**5**	**2**	**3**	**1**	**1**	**51**
	Deceased	Male	0	2	0	0	1	0	0	0	0	**3**
		Female	0	0	0	0	0	0	0	0	0	**0**
		Total	**0**	**2**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**3**

Table 8: 2009 Total SET Trainees by Specialty and Status (cont)

Fellowship status	Accepted Fellowship	Male	3	38	6	56	9	0	6	10	9	**137**
		Female	0	19	1	3	5	0	3	3	1	**35**
		Total	**3**	**57**	**7**	**59**	**14**	**0**	**9**	**13**	**10**	**172**
	Eligible - in process	Male	2	12	3	27	8	1	1	4	6	**64**
		Female	0	3	0	0	4	0	2	1	0	**10**
		Total	**2**	**15**	**3**	**27**	**12**	**1**	**3**	**5**	**6**	**74**
	Eligible - no application	Male	0	0	1	0	1	0	0	0	0	**2**
		Female	0	0	0	1	0	0	0	0	0	**1**
		Total	**0**	**0**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**3**
Total Active		Male	36	313	41	256	54	13	63	95	40	**911**
		Female	5	135	11	17	39	12	24	24	12	**279**
		Total	**41**	**448**	**52**	**273**	**93**	**25**	**87**	**119**	**52**	**1190**

Table 9: 2010 Number and Percentage of Active SET Trainees by Specialty and Location - January to April

		Australia		New Zealand		Overseas		Combined	
		No.	%	No.	%	No.	%	No.	%
Cardiothoracic	Male	30	3.0%	4	2.1%	0	0.0%	34	2.8%
	Female	5	0.5%	0	0.0%	0	0.0%	5	0.4%
	Total	**35**	**3.5%**	**4**	**2.1%**	**0**	**0.0%**	**39**	**3.2%**
General Surgery	Male	272	26.9%	43	22.4%	0	0.0%	315	25.8%
	Female	123	12.1%	25	13.0%	0	0.0%	148	12.1%
	Total	**395**	**39.0%**	**68**	**35.4%**	**0**	**0.0%**	**463**	**37.9%**
Neurosurgery	Male	40	3.9%	5	2.6%	0	0.0%	45	3.7%
	Female	10	1.0%	1	0.5%	1	6.3%	12	1.0%
	Total	**50**	**4.9%**	**6**	**3.1%**	**1**	**6.3%**	**57**	**4.7%**
Orthopaedic	Male	200	19.7%	53	27.6%	1	6.3%	254	20.8%
	Female	17	1.7%	3	1.6%	1	6.3%	21	1.7%
	Total	**217**	**21.4%**	**56**	**29.2%**	**2**	**12.5%**	**275**	**22.5%**
Otolaryngology Head & Neck	Male	52	5.1%	4	2.1%	0	0.0%	56	4.6%
	Female	30	3.0%	11	5.7%	0	0.0%	41	3.4%
	Total	**82**	**8.1%**	**15**	**7.8%**	**0**	**0.0%**	**97**	**7.9%**
Paediatric	Male	11	1.1%	2	1.0%	0	0.0%	13	1.1%
	Female	10	1.0%	1	0.5%	0	0.0%	11	0.9%
	Total	**21**	**2.1%**	**3**	**1.6%**	**0**	**0.0%**	**24**	**2.0%**
Plastic & Reconstructive	Male	59	5.8%	13	6.8%	0	0.0%	72	5.9%
	Female	21	2.1%	7	3.6%	0	0.0%	28	2.3%
	Total	**80**	**7.9%**	**20**	**10.4%**	**0**	**0.0%**	**100**	**8.2%**
Urology	Male	72	7.1%	13	6.8%	8	50.0%	93	7.6%
	Female	21	2.1%	3	1.6%	1	6.3%	25	2.0%
	Total	**93**	**9.2%**	**16**	**8.3%**	**9**	**56.3%**	**118**	**9.7%**
Vascular Surgery	Male	33	3.3%	3	1.6%	1	6.3%	37	3.0%
	Female	7	0.7%	1	0.5%	3	18.8%	11	0.9%
	Total	**40**	**3.9%**	**4**	**2.1%**	**4**	**25.0%**	**48**	**3.9%**
Total	Male	769	75.9%	140	72.9%	10	62.5%	919	75.3%
	Female	244	24.1%	52	27.1%	6	37.5%	302	24.7%
	Total	**1013**	**100.0%**	**192**	**100.0%**	**16**	**100.0%**	**1221**	**100.0%**

Table 10: 2010 Number of Active New Zealand based SET Trainees by Specialty and level of training – October

New Zealand based SET Trainees at 31 October 2010
By specialty and by SET Year

Specialty	Active SET 1	Active SET 2	Active SET 3	Active SET 4	Active SET 5	Active SET 6	Deferred (**)	Interrrupted (***)	Final Exam'n Pending	Total NZ
Cardiothoracic Surgery #				1		3				**4**
General Surgery	11	18 *	14 *	11	7	n/a	2	8	1	**72**
Neurosurgery #	2	2	2					1		**7**
Orthopaedic Surgery	10	10	13	11	13	n/a				**57**
Otolaryngology	4	6	2	1	3	n/a	1	1		**18**
Paediatric Surgery #	1		2							**3**
Plastic & Reconstructive	4	6		5	3	n/a		2		**20**
Urology ##	1	3	4	2	4		1	1		**16**
Vascular Surgery #		2	2	1		n/a	1			**6**
Totals	**33**	**47**	**40**	**31**	**30**	**3**	**5**	**13**	**1**	**203**

* includes 1 part time trainee
** trainees who have delayed starting their training (usually by one year)
*** trainees who have begun their training and have subsequently been approved to interrupt (eg. for research, parental leave, health reasons etc)

binational programmes; all years of training cannot be undertaken in NZ

final year trainees most often in approved overseas posts

Table 11: New Fellows by Specialty 2002 – 2009

	2002	2003	2004	2005	2006	2007	2008	2009
Cardiothoracic	6	7	6	8	9	4	10	6
General Surgery	62	47	44	76	71	91	76	70
Neurosurgery	1	3	7	6	13	16	18	9
Orthopaedic	41	46	46	56	49	62	43	70
Otolaryngology Head & Neck	17	15	16	19	14	27	13	17
Paediatric	0	1	1	1	2	3	3	3
Plastic & Reconstructive	15	14	15	20	13	24	23	10
Urology	9	13	13	14	12	23	18	15
Vascular Surgery	1	1	4	10	5	12	5	12
Total	**152**	**147**	**152**	**210**	**188**	**262**	**209**	**212**

Note: These numbers include a small number of IMGs as well as the former trainees who completed all of the requirements of the training program

Table 12: New Fellows by Specialty 2010 (as at June, 2010)

	Trainee	IMG	**Total**
Cardiothoracic	0	2	**2**
General Surgery	41	13	**54**
Neurosurgery	7	2	**9**
Orthopaedic	43	3	**46**
Otolaryngology Head & Neck	15	2	**17**
Paediatric	3	1	**4**
Plastic & Reconstructive	9	1	**10**
Urology	10	3	**13**
Vascular Surgery	2	1	**3**
Total	**130**	**28**	**158**

Note: the statistics in Table 13 relate only to the trainees and IMGs who passed the May Fellowship Examination

Table 13: New Fellows by Specialty and location 2007

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	**AUS**	NZ	O/S	**Total**
Cardiothoracic	0	1	0	0	0	0	1	0	**2**	2	0	**4**
General Surgery	2	24	1	14	4	2	21	4	**72**	9	10	**91**
Neurosurgery	0	4	0	4	2	1	1	1	**13**	2	1	**16**
Orthopaedic	2	18	0	13	5	1	10	2	**51**	9	2	**62**
Otolaryngology Head & Neck	0	6	0	5	1	0	7	3	**22**	4	1	**27**
Paediatric	0	1	0	0	0	0	1	0	**2**	1	0	**3**
Plastic & Reconstructive	0	5	0	1	3	1	5	4	**19**	5	0	**24**
Urology	0	7	0	4	2	1	4	1	**19**	2	2	**23**
Vascular Surgery	0	5	0	3	1	0	2	0	**11**	1	0	**12**
Total	**4**	**71**	**1**	**44**	**18**	**6**	**52**	**15**	**211**	**35**	**16**	**262**

Table 14: New Fellows by Specialty and location 2008

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	**AUS**	NZ	O/S	**Total**
Cardiothoracic	0	0	0	4	0	0	2	1	**7**	2	1	**10**
General Surgery	0	17	1	8	5	0	22	5	**58**	12	6	**76**
Neurosurgery	1	5	0	1	2	0	4	3	**16**	2	1	**18**
Orthopaedic	0	14	0	3	5	0	9	6	**37**	4	2	**43**
Otolaryngology Head & Neck	0	3	0	3	2	1	2	1	**12**	1	0	**13**
Paediatric	0	2	0	0	0	0	0	0	**2**	0	1	**3**
Plastic & Reconstructive	1	5	0	2	1	1	7	1	**18**	2	3	**23**
Urology	0	7	0	2	1	0	5	1	**16**	2	0	**18**
Vascular Surgery	0	2	0	0	0	0	2	1	**5**	0	0	**5**
Total	**2**	**55**	**1**	**23**	**16**	**2**	**53**	**19**	**171**	**25**	**13**	**209**

Table 15: New Fellows by Specialty and location 2009

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	**AUS**	NZ	O/S	**Total**
Cardiothoracic	0	3	0	0	0	0	2	0	**5**	1	0	**6**
General Surgery	1	23	1	11	6	0	15	3	**60**	9	1	**70**
Neurosurgery	0	3	0	1	1	0	2	1	**8**	0	1	**9**
Orthopaedic	0	13	1	13	6	0	13	6	**52**	14	4	**70**
Otolaryngology Head & Neck	0	7	0	1	1	0	4	0	**13**	2	2	**17**
Paediatric	0	2	0	0	0	0	1	0	**3**	0	0	**3**
Plastic & Reconstructive	0	3	0	2	0	0	2	2	**9**	0	1	**10**
Urology	0	4	0	5	0	0	5	1	**15**	0	0	**15**
Vascular Surgery	0	3	0	1	3	0	1	1	**9**	3	0	**12**
Total	**0**	**61**	**2**	**34**	**17**	**0**	**45**	**14**	**174**	**29**	**9**	**212**

Table 16: All New Zealand Fellows summarised by Admission year and Specialty

Table 17: Continuing Professional Development Participation 2007 – 2009 Triennium

Participants(a)		% Met Requirements	
Specialty	**Total**	**2007**	**2008**
Cardiothoracic	154	90%	91%
General Surgery	1315	93%	92%
Neurosurgery	185	97%	97%
Orthopaedic	307	89%	86%
Otolaryngology Head & Neck	400	95%	96%
Paediatric	91	97%	95%
Plastic & Reconstructive	339	98%	94%
Urology	326	95%	97%
Vascular Surgery	147	94%	97%
Subtotal	3264	94%	94%
Obstetrics & Gynaecology	0	100%	0%
Ophthalmology	11	71%	65%
Total	**3275**	**94%**	**93%**
Location			
ACT	45	96%	94%
NSW	893	93%	94%
NT	15	100%	100%
SA	237	94%	94%
QLD	527	94%	93%
TAS	64	91%	94%
VIC	715	92%	90%
WA	249	90%	94%
AUS	**2745**	**94%**	**94%**
NZ	399	99%	97%
O/S	131	94%	90%
Total	**3275**	**94%**	**93%**