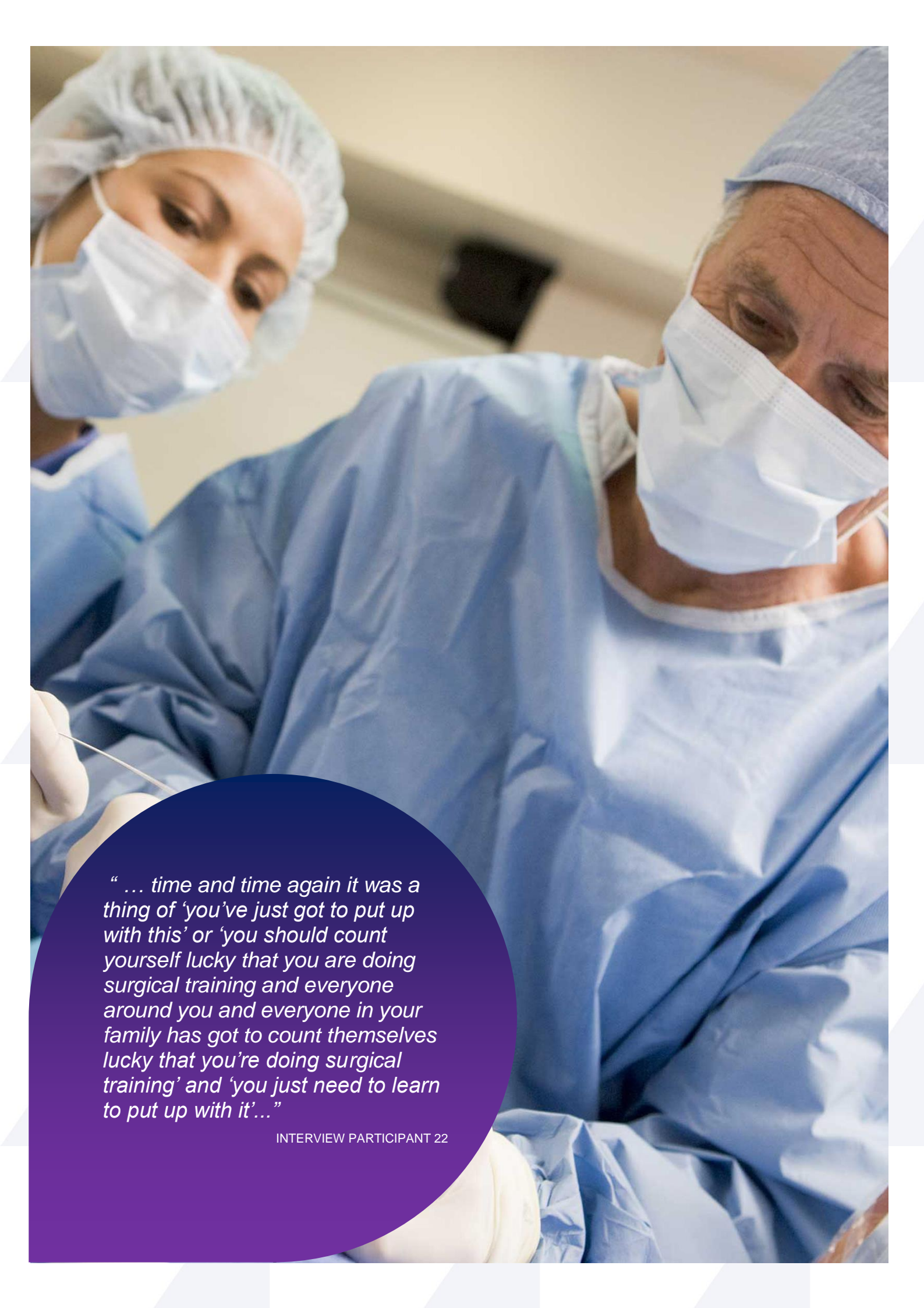


**Final Report
April 2016**

***A study exploring the
reasons for & experiences
of leaving surgical training***

A photograph of two surgeons in an operating room. They are wearing blue scrubs, white surgical masks, and blue bouffant caps. The surgeon on the right is older, with visible wrinkles, and is holding a surgical instrument. The surgeon on the left is younger. They are both looking down at their work. The background is a blurred operating room environment.

“ ... time and time again it was a thing of ‘you’ve just got to put up with this’ or ‘you should count yourself lucky that you are doing surgical training and everyone around you and everyone in your family has got to count themselves lucky that you’re doing surgical training’ and ‘you just need to learn to put up with it’...”

INTERVIEW PARTICIPANT 22

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Executive summary





EXECUTIVE SUMMARY

PARTICIPANTS

A total of 169 trainees who withdrew from surgical training between 2008 and 2015 were invited to participate in the study. Seven trainees contacted RACS and/or the Ardnell Group to opt out of the study. This provided a total study cohort of 162 previous RACS trainees.

A total of 80 previous RACS trainees (58.8% women and 44% general surgery trainees) completed the survey out of the study cohort of 162. This resulted in a response rate for the survey of 49%.

A total of 22 volunteers (54.5% women and 59% general surgery trainees) completed a follow up interview during the study period.

PROCESS

The study to explore the reasons and experiences of leaving surgical training was conducted in two parts. The first part of this study was an online survey. In the survey we explored multiple potential reasons for withdrawal and the experiences leading up to and at the time of withdrawal itself. The survey was open for a six-week period with regular scheduled follow-up, designed to maximise the response rate. Achieving a response rate approaching 50% is considered positive and provides reasonable confidence that the respondents were representative of the full cohort.

The follow-up part of this study was conducted over a seven-week period as a series of semi-structured interviews. The interviews, which were conducted by phone, allowed for in-depth exploration of the reasons for withdrawal from surgical training. The interviews also provided an appropriate confidential format to identify any previously undisclosed reasons for withdrawal which participants may have felt unable to share or elaborate fully in the survey format. Participants were able to expand on their experiences and use these to suggest recommendations for future improvements to training.

MAJOR FINDINGS

Survey & interviews participants and process

In general the experiences reported by survey respondents and interview participants were sub-optimal. The narratives were of people who had struggled with a difficult decision in isolation and often for a considerable period of time. Participants were positive and professional given the extent and nature of the difficulties they had experienced in training and when withdrawing. They had generally managed to 'make good' of their experience and the majority were pursuing careers in other medical specialties. In their conduct in the survey and interview processes they presented as considered, compassionate and understanding of the difficulties for their seniors and the College system. They had often been severely impacted by their experiences including physical, psychological stress and impact on family and personal lives. They participated because they wanted their stories to be heard. They also participated because they wanted things to improve for the trainees who came after them.

Further details on the study participants and process is available on pages 8 to 17 of this report.



Reasons for withdrawal from training

Typically, the decision to leave was the result of cumulative and varied experiences and in most cases there was a significant period of time before the decision to leave was ultimately made.

The circumstances leading to withdrawal could be grouped under three major themes:

- Inflexibility in the training programme
- An unacceptable culture in which to learn
- Surgery being the wrong career choice including surgery as an unattractive lifestyle choice

Many participants expressed deep regret about leaving surgical training. They were hopeful that reasonable changes can be made to the training programme to enhance retention into the future and also to improve the context in which surgical care is delivered.

Reasons for withdrawal are further outlined on pages 24 to 35 of this report.

The overall experience of surgical training

Whilst some experiences in training were positive the majority described were not or had a negative component. In this study we attempted to learn from the total experience that participants underwent. This involved in-depth evaluation of all aspects of the training experience and of the experience of leaving training and a subsequent focus on practical suggestions for improvement. This included participants describing what would have improved their own experience, what would have enabled them to complete training successfully and also what would have made their withdrawal more satisfactory.

In terms of overall training experience the participants presented as being well versed in what surgery involved and they had plentiful practical experience of surgery prior to entering the training programme. It was notable that undergraduate and junior doctor experiences of surgery were more positive than those whilst on the training programme. In their pre-training experiences the participants had typically experienced surgical working environments that promoted learning in a safe culture. This was clearly described in particular in smaller hospitals and for rural settings. The way in which these positive experiences are achieved should be clearly understood and promulgated.

A culture of discrimination and bullying was reported and routinely contributed in some form to the final decision to leave surgical training. Some participants reported sexual harassment. Some minor gender differences were evident but the experiences of both men and women in the training programme were inappropriate for a professional education or workplace environment.

Suggestions to improve training included, but were not limited to, increased levels of supervision, training flexibility, stronger mentoring pathways for trainees and supervisors and consistency across sites with the balance of training requirements and service provision.

There were reported discrepancies between the experiences of those in general surgical training compared to training in another surgical specialty with a higher level of dissatisfaction from trainees who withdrew from other surgical specialty training.

Additional information on the overall experience of surgical training is provided on pages 42 to 45 of this report.

The experience of assessment whilst in surgical training

In general participants were not vociferous about the examination experiences and focussed their commentary on assessments in the clinical environment, in particular a perceived lack of objectivity and content validity.

There should be no discrepancies between assessment outcomes and the perception of the trainee's ability as a surgeon. And yet participants in this study were often confused by variance between what they were told and what was formally recorded. The desire for constructive and corrective feedback from participants was reported as being of paramount importance to them. Unfortunately good feedback was not a routine experience.

Assessment experiences are further outlined on pages 47 to 52 of this report.



Clinical supervisors, mentors and role models

The reported prevalence of poor supervision was alarming. An unacceptable culture in which supervision is practiced requires strategies that are primarily focussed on improving the nature and extent of the supervision itself rather than teaching trainees how to deal with it.

Further investigation into potential differences in supervisor style between general and other surgical specialty branches of training is warranted. In general, supervision in the other surgical specialties was the focus of more criticism than in general surgery. Unprofessional behaviour in supervisors was more common in the other surgical specialties.

Mentoring was viewed as being a desirable adjunct to surgical training. However it was generally perceived as a means to support the trainees through poor supervisory experiences rather than a means to provide coaching that would improve their capabilities in surgery.

The lack of positive role models was reported as being a strong contributor to withdrawal from training. Elements of appropriate role modelling that were perceived to be absent included having good work-life balance, providing supervision and behaving professionally.

The need for supervisor development across general and other surgical specialty training was very evident. In particular, providing accurate and constructive feedback seems to be a general need. For all those involved in assessing trainees there is considerable room for development in providing fair and accurate assessments, assessor calibration and exploration of bias in assessment.

Additional details on supervision and mentoring are provided on pages 54 to 62 of this report.

Training programme administration, organisation and governance.

Inflexibility and a lack of transparency in training allocations and structure was frequently reported by study participants to cause major dissatisfaction. Participants did not accept the rationale that their clinical allocations were justifiable by the argument that they were providing a balanced range of clinical experience. Given the high level of variability in clinical presentations it seems unlikely that the number of moves within training experienced are necessary. Certainly the lack of predictability, warning and consideration for personal circumstances is difficult to understand. Changes to the allocation system are required to increase trainee satisfaction and reduce attrition.

There were reports of an incompatibility between training and family life and healthy work-life balance. Participants were realistic about the training requirements and many were conflicted about prioritising training responsibilities at the expense of everything else in their lives. Reform is required to make it possible to have flexible training and a career in surgery that embraces part-time opportunities and accommodates family life. There is a need for further exploration to understand how interruptions are currently used and of the impact of interruptions on training.

Pages 64 to 71 include further information on the training programme administration and governance of this report.

The experience of leaving training if necessary and appropriate

Typically, the opportunity to participate in this project was received positively by those who took part. Evaluating the experiences leading up to withdrawal and also of the leaving process in particular was perceived to be a welcome opportunity to have views and experiences heard. The vast majority of interview participants stated that they would have engaged in a similar process at the time of withdrawal to help with ongoing refinements to training for future trainees. They also indicated that the process of participation in this study was helpful in itself to assist them in resolving issues related to their experiences in surgical training.

Despite leaving surgical training, many participants remain committed to surgery. Articulated pathways out of specialist training to retain these committed and skilled individuals in the surgical profession should be considered.

Leaving experiences are further detailed on pages 37 to 40 of this report.



SUMMARY OF AREAS ADDRESSED BY THE RECOMMENDATIONS

An extensive range and number of recommendations are being made in this report. These are considered to be warranted given the level of participation in the study and also the nature of the reports made. In particular, inappropriate professional behaviour on the part of some supervisors, trainees who report being exposed to situations where they felt unable to provide safe and effective care (either because they are so affected by the culture of training or by the supervisory practices themselves) and a failure to provide an effective educational experience on a consistent basis have guided the production of the recommendations. We are also cognisant of the amount of existing work and effort being put into improving surgical training by the College prompted by other reports and research. As such we recognize that our findings and recommendations need to be considered in a broader context. This section provides a summary of the areas which are addressed by the recommendations and overview of the areas which they address.

The overall experience whilst in surgical training:

- The culture of surgical training including gender differences was particularly influential on this cohort of trainees who were subject to discrimination, bullying and sexual harassment.
- Experiences in general and other surgical specialty training differ with other surgical specialty training generally less favourably perceived.
- Opportunities for building on best practice such as:
 - Rural training in surgery
 - Undergraduate and junior doctor experiences in surgery.

A summary of the overall experience recommendations is provided on page 81 of this report.

The experience of assessment whilst in surgical training:

- The need for assessor training to address two major areas of concern:
 - Lack of validity and objectivity of the assessment process in the workplace
 - Provision of timely, accurate and constructive feedback to guide learning and improvement effectively.

A summary of the recommendations on assessment is provided on page 81 of this report.

The experience of clinical supervision and need for mentoring:

- The paucity of effective surgical role models:
 - Both men and women talked about the lack of male and female role models
 - General and other surgical specialty training differences
 - The need for an appropriate work-life balance across a surgical career.
- The presence of inappropriate professional behaviour in some supervisors and contexts.
- The need for co-ordinated supervisor training across general and other surgical specialty training.

A summary of the supervision and mentoring recommendations is provided on page 82 of this report.

Training programme administration, organisation and governance:

- Recommendations relate to inflexibility in training allocations and structure, transparency and equity. In particular the following two areas are highlighted:
 - Incompatibility of training with family life and healthy work-life balance
 - Need for further exploration of the impact of interruptions from training.

A summary of the training administration recommendations is provided on page 82 of this report.

The experience of leaving the training programme if necessary and appropriate:

- Recommendations relate to early unbiased intervention, respectful communication and adequate support and guidance for both when deciding whether to leave and throughout the process of leaving.

A summary of the leaving experience recommendations is provided on page 83 of this report.





How was the study
conducted?





HOW WAS THE STUDY CONDUCTED?

SURVEY DESIGN, ADMINISTRATION AND TIMELINE

This first part of this study to explore the reasons and experiences of leaving surgical training was conducted as an online survey. In the survey we explored multiple potential reasons for withdrawal and the experiences leading up to and at the time of withdrawal itself. The survey instrument was developed by the Ardnell Group in consultation with RACS. Feedback was provided in two rounds by three Senior Fellows for the College involved in educational governance and management.

The survey was arranged for administration into two parts. The first part explored reasons for withdrawal from training. The second part related to training experiences (please see *Appendix C* for a copy of the survey instrument). The survey was programmed online by RACS staff using the survey tool SurveyMonkey® and tested by the Ardnell Group prior to commencement of the study. The survey access was then handed over from RACS and was administered in full by the Ardnell Group consultants to ensure confidentiality for participants. A pilot was also conducted to test the feasibility and pragmatics of survey wording and online design and functionality.

The online survey was available from Wednesday 14 October 2015 to Wednesday 25 November 2015 (a six-week period) with regular scheduled follow-up, designed to maximise the response rate.

It was recognized that the study cohort had no ongoing relationship to RACS and may have left in less than favourable or ideal circumstances. So to mitigate against an anticipated low response rate from this group, communication about the study was distributed via multiple modalities including email, mail, SMS text message and the SurveyMonkey® system itself. The table below outlines the communication process with study cohort regarding the survey.

Date	Survey Communication
Thursday 08 October 2015	Study introduction email sent by RACS (see <i>Appendix A</i>)
Wednesday 14 October 2015	Study invitation sent electronically to 169 trainees via SurveyMonkey® by Ardnell Group (see <i>Appendices B and C</i>)
Monday 19 October 2015	Hardcopy letter sent by Ardnell Group to 147 people who hadn't opted out of the study or completed the survey within the first 48 hours (see <i>Appendix B</i>). The Ardnell Group received 12 'return to sender' notifications
Tuesday 27 October 2015	Individual email reminders sent by Ardnell Group with a link to the online survey (sent to 122 people). Ten email bounce back notifications were received and eight trainees were then sent a text message reminder.
Friday 13 November 2015	Text message reminder sent by Ardnell Group to those with an available mobile number (sent to 95 people)
Monday 23 November 2015	Individual email reminder sent by Ardnell Group (sent to 99 people). Seven email 'bounce back' notifications were received and were all sent a text message reminder.
Wednesday 25 November 2015	Study reminder sent via SurveyMonkey® (sent to 84 people) Text message reminder sent by Ardnell Group to trainees with a SurveyMonkey® reminder return (sent to six people)

Once the survey was completed the participants were invited to undertake a voluntary follow up interview to explore their training and withdrawal from training experiences further and to clarify their survey responses.



PHONE INTERVIEW DESIGN, ADMINISTRATION AND TIMELINE

The follow-up part of this study to explore the reasons and experiences of leaving surgical training was conducted as a series of in-depth semi-structured interviews.

The interviews, which were conducted by phone, allowed for in-depth exploration of the reasons for withdrawal from surgical training. The interviews also provided an appropriate confidential format to identify any previously undisclosed reasons for withdrawal which participants may have been unable to share in the survey format. Participants were able to expand on their experiences and use these to suggest recommendations for future improvements. Recruitment for the interviews was by self-referral from the survey. However participation in the survey was not considered a pre-requisite for participation in the interviews.

As the study employed a sequential mixed method design, an interim analysis of the survey responses was required to inform the interview design. A thematic analysis of the first 63 survey responses was undertaken to identify and examine patterns within the survey data to enable a meaningful interview pro-forma to be created. These 63 respondents represented 38.9% of the total study cohort. This response rate was achieved 10 days prior to the survey closing date. There was no particular significance to the time or number selected for interim review of results with these being selected for entirely pragmatic scheduling reasons.

The interview pro-forma was developed by the Ardnell Group and reviewed by RACS (please see *Appendix D* for a copy of the interview pro-forma). The interviews consisted of four parts as follows:

- The factors leading up to withdrawal from training and the impact these had on participants
- Participant views on how surgical training should be changed to enhance retention
- Participant views on how the experience of leaving surgical training could be improved
- Final messages to RACS having withdrawn from training.

All interview questions were optional and participants could decline to answer any question at any time. In accordance with the NHMRC Human Research Ethics Guidelines (Reference: EC00287), all participants were asked to provide formal written consent to participate in the interview.

Interview bookings were coordinated individually with participants by the Ardnell Group. Interviews were conducted by phone as a one-on-one discussion with a member of the Ardnell Group project team at a time suitable for the participant. Interviews were undertaken using the teleconference service Chorus Call® and confidential recordings were provided directly to the Ardnell Group from Chorus Call® for analysis purposes. The interview recordings were transcribed verbatim and participants were provided with an electronic copy of their own interview transcript via email for validation and approval. Three non-validated transcripts were not included in the final analysis.

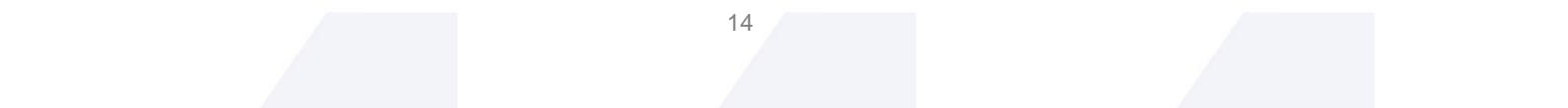
Interviews were conducted between 10 December 2015 and 04 February 2016 (a seven week period). The table below outlines the communication process with study participants regarding interviews.

Date	Interview Communication
From Wednesday 14 October 2015	Email update on interview process sent to those who indicated a willingness to participant in an interview in their survey response
Monday 30 November 2015	Interview consent forms distributed via email
From Saturday 19 December 2015	Interview transcript validation process commenced via email
Sunday 20 December 2015	Email reminders sent to participants yet to schedule an interview
Thursday 21 January 2016	Email reminders sent to participants yet to schedule an interview
From Tuesday 26 January 2016	Email reminders sent to interviewees to return validated transcripts





Who participated in
the study?





WHO PARTICIPATED IN THE STUDY?

STUDY COHORT

A total of 169 trainees who withdrew from surgical training between 2008 and 2015 were invited to participate in the study. Trainees who had left training for a regulatory reason or had been dismissed were not included in this study. Seven trainees contacted RACS and/or the Ardnell Group to opt out of the study. This provided a total study cohort of 162 previous RACS trainees.

A copy of demographic information of the study cohort was provided to the Ardnell Group by RACS. This included, where available, trainee name, postal address, email address, telephone number, gender, and a record of exam attempts.

SURVEY RESPONDENTS

A total of 80 previous RACS trainees completed the survey out of the study cohort of 162. This resulted in a response rate for the survey of 49%.

The breakdown of survey responses by gender is:

- 47 (58.8%) female
- 32 (40.0%) male
- 1 (1.3%) unknown (i.e. didn't complete the demographic section of the survey)

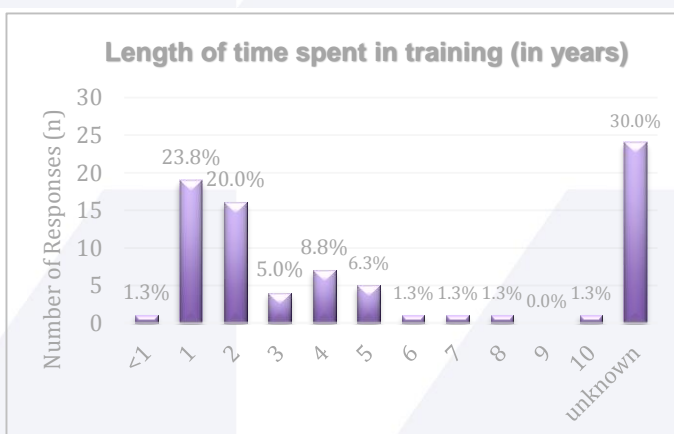
56.6% of the total number of females within the study cohort participated in the survey. The response rate for males was slightly lower with 40.5% of males in the study cohort participating in the survey.

Survey respondents commenced surgical training between 2002 and 2014 and withdrew between 2006 and 2015. It is noted that 5.1% of survey participants withdrew prior to 2008 so were reporting on the Basic Surgical Training (BST) programme rather than the Surgical Education Training (SET) programme. These responses have been included in the overall data set and subsequent reporting.

The overall length of time spent in training for survey respondents ranged from less than one year up to 10 years. Almost 50% of respondents did withdraw from training within the first two years of undertaking surgical training. The most frequently reported time spent in training was 1 year.

It is noted that the information provided in the demographic section of the survey was self-reported and subject to potential reporting error. For example, one survey respondent did indicate that they withdrew earlier than commencing training. This may be explained by the trainee withdrawing after selection/prior to commencing training or a self-reporting error.

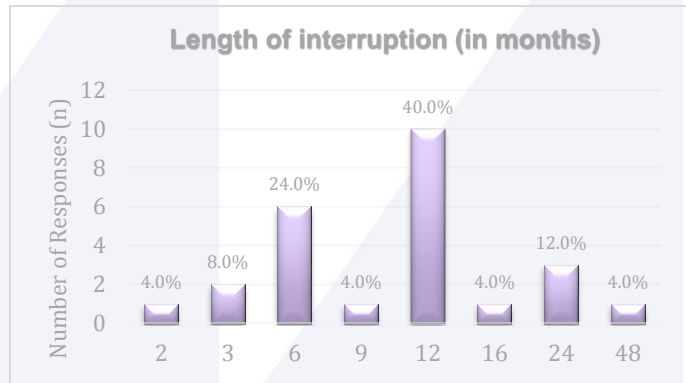
Many survey respondents had progressed through training prior to withdrawing. The SET levels at the time of withdrawal ranged from SET 1 to SET 7. Approximately 30% of respondents were in SET 3 or above at the time of withdrawal.





It is a common occurrence in specialty training for those considering withdrawal to undertake periods of extended leave from training. Respondents were asked whether they undertook any period of interruption to their training prior to the decision to leave. In total, 31.3% of respondents indicated they formally interrupted with the average length of interruption being 12 months.

Almost 50% of respondents were undertaking training in general surgery rather than another specialty at the time of withdrawal. All surgical specialties were represented in the survey responses.



New South Wales, Queensland and Victoria were the top three states that respondents reported they were located at the time of withdrawal.

More than 50% of respondents were placed at a metropolitan hospital at the time of withdrawal and approximately 20% were placed in rural or regional hospitals. Respondents ranged in age from 26 – 30 to over 50 years old. The majority of respondents were aged between 30 – 40 at the time of withdrawal.

More than 60% of respondents reported they were an Australian citizen. European was the highest ethnicity represented with more than 50% selecting this option. The next highest ethnicity represented was Asian at approximately 20%. No respondents reporting as Aboriginal, Torres Strait Islander or Maori participated in the study. Only 5% of respondents reported that they completed the International Medical Graduate (IMG) pathway prior to entry into surgical training.

The majority of survey respondents undertook their primary medical degree at an Australian University. The top three universities where respondents reported they completed their primary medical degree were the University of Sydney, University of Queensland and University of New South Wales. Primary medical degrees were completed by survey respondents between 1985 and 2011.

Of the 43 participants that responded listing other qualifications that they had completed, 11 (25.5%) indicated that they had completed another Fellowship at the time of reporting. These may have been completed before or after participation in the surgical training programme.

See *Appendix E* for a full breakdown of all demographic details for the survey respondents and *Appendix F* for a full summary of survey responses. Survey responses are provided as frequency counts and percentages as appropriate for each item. Sub-group analysis was also performed to allow the following comparisons to be made:

- Gender
- Holding Fellowship of another College
- Whether an interruption to training was taken and, if so, the length of interruption
- General versus other surgical specialty training



INTERVIEW PARTICIPANTS

A total of 22 volunteers completed a follow up interview during the study period. These interviews provided the opportunity to explore further participant's reasons for withdrawal from surgical training and experiences during training overall leading up to their decision to leave.

The breakdown of the interviewees by gender is:

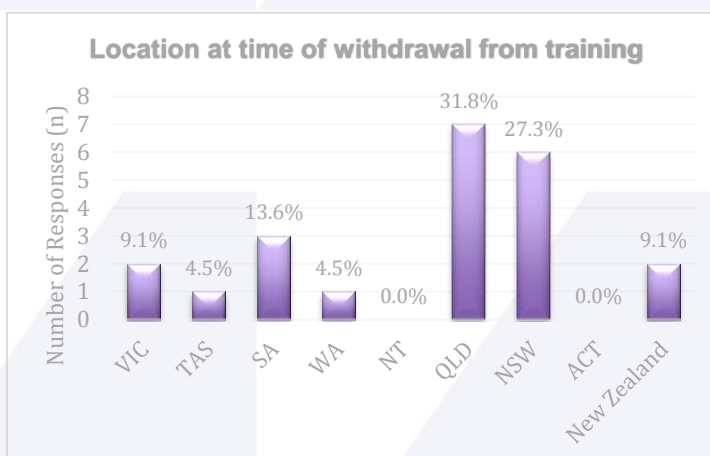
- 12 (54.5%) females
- 10 (45.5%) males

14.5% of the total number of females within the overall study cohort participated in an interview. The response rate for males was slightly lower with 12.7% of males in the overall study cohort participating in an interview.

Similar to the survey, many interviewees had progressed through the training programme prior to withdrawal. Interviewees ranged across all levels of SET at the time of withdrawal. Almost 50% of interview participants were in SET 3 or above at the time of withdrawal.

Almost 60% of participants were undertaking general surgery rather than another specialty at the time of withdrawal.

Queensland, New South Wales and South Australia were the top three states that respondents reported they were located at the time of withdrawal.



No further comparisons with the study cohort demographic information were possible.

The respondents were asked to confirm what they had done since leaving surgical training. This information is summarised in the following table.

Response category	Frequency Count = n (%)
Fellow of the Royal Australian College of GPs	5 (22.7%)
General Practice Trainee	1 (4.5%)
Emergency Medicine Trainee	1 (4.5%)
Intensive Care Trainee	4 (18.2%)
Radiology Trainee	2 (9.1%)
Fellow of the Royal Australasian College of Physicians	1 (4.5%)
Royal Australasian College of Physicians Trainee	3 (13.6%)
Completing a PhD	1 (4.5%)
Completing a Masters degree	2 (9.1%)
Surgical Assisting	4 (18.2%)
Medical Educator	1 (4.5%)
Raising a family	2 (9.1%)
Other (e.g. medical advisor)	2 (9.1%)

See *Appendix G* for a full breakdown of all demographic details for the interview participants.





Why had they
chosen surgery?





WHY HAD THEY CHOSEN SURGERY?

SUMMARY

The initial motivation for joining the surgical education training programme was explored with the 22 interview participants. The responses to this question revealed a group that were exceptionally committed to surgical training. In general they had positive prior experiences of surgery which positioned them to make informed choices about joining the training programme. Experiences in rural hospitals appeared to be particularly positive and influential. Equally, undergraduate experiences in surgery appeared to be markedly different and more positive than experience within the training programme itself.

As such, a massive disjuncture was evident between their pre-training and training experiences which is difficult to account for.

DETAILED ANALYSIS:

Two types of responses were evident to this question. The first was the participants who had always wanted to do surgery.

“I always thought I wanted to be a surgeon since the age of 13 or 14 years old. That was what was always going to be my chosen career path. I applied to medicine with the intent that I would go onto surgical training from the get go.” [Interview participant 11]

These respondents tended to have had affirming and positive experiences in medical school and subsequently.

“The question was why surgery and the answer is I’d always wanted to do it, always enjoyed it and I had been exposed to it.” [Interview participant 17]

And sometimes even a specific surgical specialty branch.

“I was always interested in neurosurgery. I was always interested in the brain and neuroanatomy and did a lot of research in neurosurgery as a medical student and an intern. As a result I thought it would probably be a good specialty for me.” [Interview participant 10]

The second response type was from those who had been persuaded by positive clinical experiences in surgery during medical school or junior doctor experience.

“I enjoyed surgery as a medical student. ... I enjoyed operating and being in theatre.” [Interview participant 18]

What was particularly striking about the majority of responses to this question was the number of participants who described these positive early experiences in surgery. Many were experienced across undergraduate and junior doctor levels. So their decisions to enter surgical training appeared to be well informed by positive personal experience. As such, the respondents certainly cannot be described as a naïve group when entering training.

Many of the positive experiences described were in rural placements.

“I did quite a few surgical rotations – general surgical, orthopaedics, vascular and a urological term. I think being in the country there are less doctors for a start and you are given more responsibility at a junior level and so I got to experience probably what a more senior registrar would get to experience ... I really enjoyed that experience and that exposure. I had pretty good supervision at the time. There were a couple of surgical consultants that were working at the hospital that were very enthusiastic teachers and very supportive and you’d probably describe them more as a mentor rather than a simple professional supervisor. They took an interest in my personal as well as my professional life.” [Interview participant 8]

A sizeable proportion of the participants described that they had been attracted by specific features of the profession such as the practical nature of the discipline.

“I wanted to do surgery because I was interested in operating, using my hands to heal and to have a problem that I could be involved in solving.” [Interview participant 3]

“I work well with my hands. I’ve been told that I have a very good depth perception. I felt it came natural to me, I quite liked it and felt I was quite good at it as well.” [Interview participant 19]



Many were attracted by the fact that the work combines technical skills with problem-solving activities. Responses were, typically, patient-focussed in terms of healing and resolving patient's problems definitively.

Additionally, respondents viewed the profession as being clear and well defined and were attracted by the solution focussed aspect of operating to resolve the patient's problems:

"...straight forward specialty compared with a lot of the other ones in medicine." [Interview participant 3]

"...preferred the surgical side mainly because it was very practical, I felt useful and I really enjoyed the technical side and the thought that you are really helping people. For example even acute appendicitis you take their appendix out and they leave hospital well again. It was very emotionally satisfying from that point of view as well." [Interview participant 8]

"It was just that I enjoyed the practical skills of surgery, that in theatre work and also seeing patients in the ED and the nature of surgery where you solve the problem relatively quickly, or deal with it quickly, in a relatively definitive way, that aspect of surgery always appealed to me the same way." [Interview participant 16]

I remember having a conversation as a medical student with other medical students about what career path you take once you get into your internship and how you get on training programmes. I remember hitting the panic modes because they basically said if you like surgery and want to get into surgery there's twenty million boxes you've got to tick and I kind of went well I'll start ticking them now. It just became a mission essentially. I didn't really explore anything else. I went 'yip that's what I'm doing, there are all the boxes'. There were so many things you had to do to get in, you didn't have time to do anything else or think about anything else...

INTERVIEW PARTICIPANT 18

... When I got on initially I was ecstatic and then I was like 'Do I really want to do this?' Hang on, I've made this my mission and haven't really thought about it

INTERVIEW PARTICIPANT 21

Given the high degree of awareness of the actual work of surgery and the enjoyment of the practice of surgery at a junior level, it was somewhat surprising that this group continued to have generally poor training experiences. For some, the feeling was that fulfilling the requirements for training blinkered them to the 'reality' of surgical training, and that consequently they didn't stop to reflect adequately on whether it was actually what they wanted to do.

There were several descriptions of feeling misled by positive placements prior to training commencing.

... I did all of my junior years at [hospital name] and really enjoyed my surgical terms somewhat unexpectedly. I had no preconceived ideas about what I wanted to do and had a really great time on one of the general surgical teams as an intern and then as a resident. It just gelled and I seemed to get on with the registrars and bosses ... I really enjoyed that part of my career and so relatively early was supported by those bosses to get onto the training programme without doing much else to be perfectly honest. ... I did all the different specialties that I could get my hands on as well as a lengthy general surgical term. ... my bosses at the time just encouraged me and said 'you are the type of person that will do well in surgery'. They gave me a ... non-accredited, non-training registrar job so I could get a better taste of what it would be like. ... I did a thoracic term for six months and then a general term for six months. I had good bosses and a pretty good experience and it was then relatively easy to get on to the training programme at the end of that year. Then it all fell apart. From the beginning it was awful from start to finish. In my opinion [hospital team] are surgical utopia. They are busy, worked well together, support their junior members of staff. They had problems, they still had a 24 hour roster which is archaic and totally inappropriate. They had problems but the top down approach from the consultants was that of encouragement, training and support. It wasn't perfect but I didn't come across it much. The teams that I worked for seemed very nice and very supportive of me so I got duped into a sense of how wonderful surgery is. I got a rude shock in February of the following year. I was warned before I got to the job So my current boss that I had a lot of respect for said 'your next boss is [derogatory statement], good luck with that, see you later'. That was my very first experience of surgical training. He was right about the [derogatory statement]. That is how they talk about each other. It was a bit of a rude shock.

INTERVIEW PARTICIPANT 14



The background features a repeating pattern of light purple triangles pointing upwards. In the lower right quadrant, there is a large circle with a purple-to-blue gradient. The text is centered within this circle.

Why do trainees leave
surgical training?





WHY DO SURGICAL TRAINEES LEAVE?

SUMMARY

Trainees who withdrew from surgical training rarely did so on the basis of a single factor. And the decision was often protracted and considered over many months. Rationales provided were complex and multifactorial. Most contained an underlying critique of at least some elements of the culture of surgical training in particular and the surgical profession in general.

SURVEY COMMENTARY

The survey explored the reasons for leaving the surgical training programme in a structured fashion. See *Appendix F* for a full summary of all survey responses.

Almost 60% of survey participants disagreed that the reason for withdrawal was to change specialty pathways (e.g. surgery to anaesthetics). On the whole these trainees did not leave surgery because they wanted to pursue a different specialty. There was a gender difference in the responses to this question. Women were less likely than men to report agreement that they withdrew from training in order to change specialty pathways. Given that so many trainees subsequently re-train in a different specialty the response to this question suggests a disjuncture between the trainee's aspirations and their career pathway. This may have implications for the other 'destination' specialty training programmes who may need to deal with the difficult transition period.

... I felt that I wasn't the right fit for the culture of surgery... The surgical program wanted me to fully compromise my life outside work and I was not comfortable doing that. I found that trainees were not nurtured...I found it difficult to identify senior colleagues who I aspired to be like ...

SURVEY PARTICIPANT 13

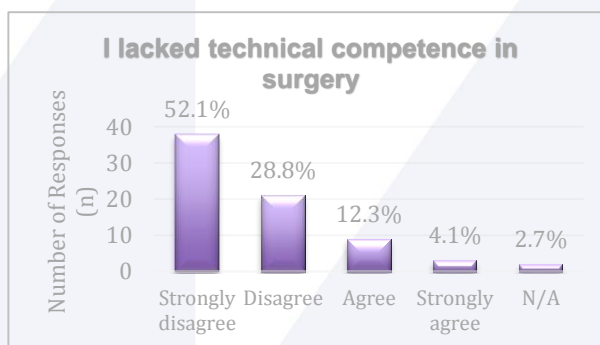
Only five respondents stated that they wished to change to a non-specialist career on leaving the surgical training programme. This suggests that, having commenced on a specialty training programme, participants are likely to pursue specialty level training even if they leave surgery. This may also be reflective of the paucity of options for non-specialist training options across the disciplines in medicine. There was a difference between the responses of the two groups of respondents who interrupted from training for less than 12 months or 12 months or more. The group who interrupted for 12 months or more were in stronger agreement that they wanted to change to a non-specialist medical career. Perhaps time passing brought a decline in motivation to undertake a further training programme.

Similarly, very few respondents were interested in changing to a different surgical specialty within surgery (e.g. general to orthopaedics). The majority of respondents who leave do not envisage a return to another surgical specialty pathway. There was a difference between the responses of the two groups of respondents who interrupted from training for less than 12 months or 12 months or more. The group who interrupted for 12 months or more were less likely to agree that they wanted to change to another surgical career. Both a resolution of the original goal for surgery occurring over time and a motivation decline are possible.

Trainees who left the surgical training programme stayed within medicine predominantly with only two trainees stating that they planned to pursue a non-medical career. This seems authentic given the participants had already worked as a junior doctor for a number of years by this stage in their career. Attrition from the medical profession as a whole is likely to be at an earlier stage and not after a commitment to specialty training had been made.



A common perception is that trainees leave because they are lacking technical competency in surgery. However, in this survey (acknowledging the limitations in self-reported competence) a large majority of respondents (over 80%) did not report that they were leaving training because they lacked technical competency. This may be a methodological issue (self-reported data) or other explanations may need to be considered. For example, is there a mismatch between the feedback that trainees are receiving and their supervisors' perceptions of their competence?



Survey participants were asked whether experiencing an adverse patient outcome contributed to their reason for withdrawal from training. Again, whilst self-report may be an issue here the responses on adverse patient outcomes are certainly consistent with those above related to surgical competence. Over 80% of respondents disagreed or strongly disagreed that they had experienced adverse patient outcomes.

Virtually no trainees stated that they anticipated that they would be returning to surgical training at a later date. This is consistent with other responses that the decision to leave training was considered at length before being made final for the majority of participants. Given most trainees withdrawing have little expectation of returning to the training programme or continuing in a surgical pathway it is essential that efforts are taken prior to withdrawal to ensure that it is the correct decision when it is made and suitable efforts are made to ensure it is the case.

... College having complete control over my life and being able to move me across the state ... without considering me or my family; bosses and mentors not having the lifestyle I aspire to; poor treatment during one particular rotation; constantly changing requirements/exams/protocols leaving huge uncertainty and doubt around direction of training.

SURVEY PARTICIPANT 31

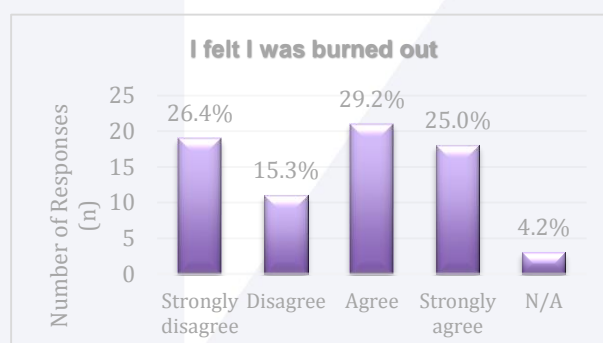
Overwhelmingly participants stated that they did not withdraw from training to avoid formal dismissal proceedings. Again, whilst self-reporting may be considered limited in this area, this is a definitive response with over 78% strongly disagreeing with the statement (of the 85% overall who disagreed or strongly disagreed). There were between group differences for those who were undergoing general surgical training and other surgical specialty training. The group in general surgical training were less likely to be in agreement that they withdrew to avoid formal dismissal.

Financial constraints and considerations were not an issue for the majority of survey respondents. Only two respondents stated that this was an issue for them. This topic was therefore not pursued in the interview follow-up.

Family and/or carer commitments, along with other topics related to personal health and well-being attracted less polarised responses. Almost 40% of survey respondents reported some degree of family and / or carer commitment.

Almost 20% of respondents reported an underlying health issue impacting on their decision to leave training.

Burnout was reported at a high level for such a junior cohort. Over half of all respondents agreed or strongly agreed that they experienced burnout. The interviews were well-placed in this study to explore the extent to which health and burnout reported were attributed, by the respondents, to their surgical training experiences.





Contrary to expectations around trainees who withdraw, the assessment process and formal lack of success in the examination process was not attributed as a common reason for withdrawal. This should be compared to the assessment experience responses in this report which reflect a cohort who are achieving positive exam outcomes on the whole.

Survey participants reported that they were not expecting unfavourable exam outcomes with almost 85% disagreeing or strongly disagreeing that a reason for withdrawal was due to anticipating unsuccessful exam outcomes. There were notable similarities in the responses made for exam

outcomes, technical competence and outcomes of clinical assessments in the respondents. More than 80% of survey participants disagreed or strongly disagreed that a reason for withdrawal was they had unsuccessful clinical assessments or were expecting unfavourable clinical assessment outcomes. In general this was a group who were progressing well with the formal requirements of training.

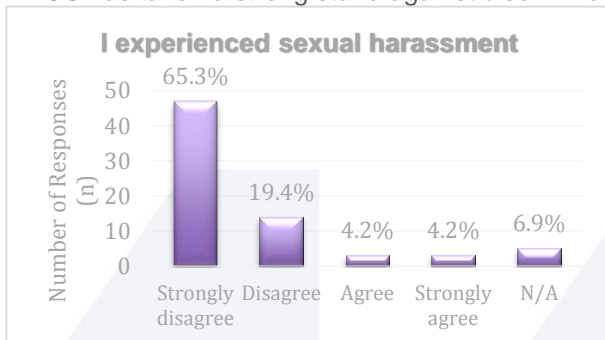
As stated in this section summary, **nearly all decisions to withdraw included some reference**

to the culture of surgical training and the surgical profession. One third of the trainees who withdrew from training did not report experiencing bullying. However, a troubling 62.5% of respondents did report bullying. This component was explored in more detail in interviews.

Fewer respondents reported that they had experienced discrimination that impacted on their decision to leave surgical training. However, **at almost one third of all respondents agreeing or strongly agreeing that they experienced discrimination this level must be seen to be unacceptably high for a professional training programme.** There was a gender difference in the responses to this question. Women were statistically significantly more likely than men to report that they agreed experiencing discrimination in training.

RACS has taken a strong stand against discrimination, bullying and sexual harassment. The levels of

sexual harassment reported as contributing to withdrawal from training are around 8%. It is interesting to note the comparatively high number of respondents (compared to other survey items) marking this item as 'Not applicable'. Does this suggest that sexual harassment is only expected within a particular group? These issues were explored in the interview process. Many accounts of the withdrawal process contained a particular culture that has no place in education or the professional workplace in which it is located.



Sixty-six survey respondents provided qualitative free-text answers to a survey question asking them to describe the main reasons and circumstances leading up to their withdrawal from training. These are summarized, quantified and provided with representative comments in *Appendix F*.



INTERVIEW INSIGHTS

Qualitative free-text responses to the survey question asking respondents to describe the main reasons and circumstances leading up to their withdrawal from training were extensive. Collectively, three themes were distilled from the responses as follows:

It was a combination of being a lifestyle choice as well as getting more of a realisation of what the job and lifestyle of a surgeon was actually like. ... In the programme we [participant and partner] were passing ships, doing nights and 24 hours that sort of stuff, one of us would be doing nights most of the time. The prospect of looking at the next five years and that probably being as best as it can get because there is no guarantee that we were going to get in the same hospital or same city together and that weighed pretty heavily on it as well. It is not easy to have family and stuff when they are not very accommodating of that and made that quite clear unless you had children with special needs and then they might take your partner into consideration whether they were on the programme or even medicine at all.

INTERVIEW PARTICIPANT 20

1. Participants experiencing inflexibility in the training programme e.g. difficulty in accessing part-time training, leave (study and parental) and access to appropriate training experiences.

2. Participants reporting an unacceptable culture, bullying, discrimination and / or sexual harassment with or without resultant burnout and health issues.

3. Participants experience of surgery being the wrong career choice for them e.g. adverse patient outcomes, lack of technical competence, concern of failure with or without resultant burnout and health issues and a lack of positive role models or lifestyle to which they could aspire.

These themes were used as an operational and organisational framework for one of the initial interview questions to ensure that focused and in depth clarification was conducted related to the reasons and circumstances leading to withdrawal from the surgical training programme

All interview participants described multiple, progressive challenging experiences that led up to a final decision to leave training. Reasons were complex and frequently involved reference to poor experiences of training (often around issues of inflexibility), poor treatment (with many references to enduring disrespectful treatment and poor interprofessional relationships) combined with a growing realisation that a surgical career was unattractive to them or that they were facing burnout.

There were multiple small factors playing into my withdrawal. One had to do with a hospital posting that was suddenly changed without mine [sic] or my supervisor's knowledge. I was basically left in limbo for half a day not knowing whether I still had a job and whether anything I was doing was going to count towards training in the next six months. There was a suggestion that I was going to be sent to a smaller town about four hours away which was quite distressing being that my partner that [sic] was also just accepted onto the programme had just relocated and we both moved in together and signed a lease ... Suddenly I had no control and I was potentially moving the next day. That was the first thing that made me realise that I was quite unhappy with where everything was going. I had a few experiences when I was a PHO whereby I felt that I was unfairly treated because I was a female as opposed to similar things that my male colleagues had done and they hadn't been reprimanded for. ... With both my partner and I being on the training programme and sort of looking to the future and the lives of our bosses and female mentors that I had exposure to, when I took everything else into account I just couldn't see that it was still worth the time and basically giving up your life for the better half of a decade to achieve the end result. It was a combination of all of those things and a three month thought process in my head before I actually made the decision.

INTERVIEW PARTICIPANT 14



SPECIFIC EXAMPLES FROM INTERVIEWS

Interview participants were asked to provide specific descriptions of their experiences. They could select an experience that was characteristic of their general experiences or one that was highly influential in a decision to leave training

Summary:

Participants attributed the **major problems in training to the surgical culture** and a perceived lack of flexibility and consideration for personal circumstances during training and beyond. Poor experiences were almost entirely cumulative with participants becoming progressively less able to tolerate or cope with them. Factors such as long working hours were endured at the outset but became intolerable as participants advanced and continued to face more experiences which they considered to be personally damaging. A significant proportion of trainees left training experiencing personal issues such as anxiety, depression, burnout and significant lack of confidence, which they attributed to their training experience.

Detailed analysis:

In general, respondents had realistic perceptions of the surgical workload and were accepting of the need to work hard and to work long hours. However relentless work hours did play a part in the final decision to leave training if other factors (such as a rejection of the surgical lifestyle or bullying) were already present.

"The main decision for me to leave was the work hours. I worked for a year in country Queensland. When you are on-call, you are on-call for 72 hours, from Friday morning all the way through to Monday morning. I wouldn't really get much sleep in that time. I'd spend the vast majority of that time in the hospital generally until 10 or 11 at night sometimes even 3 in the morning and come back in at 8 o'clock that might also include coming back in the night into emergency when I was on-call. It did something to me working that hard. Something happened. I realised I couldn't really do that forever." [Interview participant 3]

So whilst trainees were able to cope with heavy workloads in training, the perception that this experience would be ongoing, with no obvious benefit in sight, made the experience unmanageable for them. It was also reported that the working hours were unnecessary in their opinion and also impacted unfavourably on patient care and safety.

"It comes to the point where you go 'ok you want to see if I can actually work 48 hours with no sleep' great but is that the best thing for the patient and does this patient really need to be operated on at two in the morning when it safely could be done the next day? Those were kind of frustrating things but those things would have never made me quit." [Interview participant 19]

The impact of surgical training and culture was frequently experienced as being dehumanising.

"I often felt in surgical training I was not a human being, I was just the role of surgical registrar, patients hardly knew my name, I was just there to do a job and often supervisors would be too busy to see me as anything other than that." [Interview participant 2]

"When I came home and made dinner and when I woke up in the morning I didn't feel like [my name] anymore, I felt like a surgeon. Part of that was probably putting undue pressure on myself. I slipped into a culture that was very much like that. I embraced the culture because I had to." [Interview participant 3]

Many participants described feeling an unreasonable loss of control over their life and experienced unacceptable and unreasonable expectations to move without adequate warning or consideration of their personal circumstances. These expectations appeared to them to be whimsical and not based on obvious benefits in terms of their training experience. When this occurred it promoted considerable mistrust and bad will towards the College.

"... despite having being posted and having signed hospital contracts and subsequently signing leases for a year for somewhere to live ... being told on a Monday morning that I might need to move on Tuesday I was already committed and had paid significant money to move into where I had and signed leases and paid bond and things like that. I was basically told no it was not an option, the job exists and if you want to stay on the programme that is where you will go." [Interview participant 11]



You've just got to put up with this or you should count yourself lucky that you are doing surgical training and everyone around you and everyone in your family has got to count themselves lucky that you're doing surgical training and you just need to learn to put up with it.

INTERVIEW PARTICIPANT 13

Loss of control extended to personal aspects of family and personal responsibilities. In some cases participants felt as though they had to answer to the training programme for all aspects of their life. A common experience related to lack of perceived reasonable flexibility in response to a range of life events (including ill health, family responsibilities and child-rearing).

"There was a female mentor at the time who was involved in the process of looking after first year trainees. She basically said to the females in the room 'If at any time during training you would like to start a family or have more kids, if you already have a family, before you start to get pregnant you need to tell us as we don't want your life decisions to disrupt other people's training and put them at a disadvantage, you basically need to work it so that you fall pregnant in and around when rotations change so not to disrupt anyone or do a half rotation that doesn't count.' It was quite confronting. We hadn't even started the job and being told if you want to fall pregnant you tell us first and we will let you know when it suits everyone. I was not the only person to walk away from that questioning whether that's really it. ... At that point I wasn't thinking about children but I was thinking if that ever comes to be is it really that inflexible and is it really that difficult? ... It is an issue that lots of people face on a regular basis." [Interview participant 11]

"... you need to give them the impression that as a women "here is my uterus on platter take it whilst I'm training." ... This female surgeon said I had to make the decision it was either kids or surgery I couldn't have both. You can't say everything is the College's fault but ... if they claim they don't know about it ... they obviously are not in touch with the general public or their trainees. They should almost be trying to break these misconceptions and perceptions down and should be making a big deal of women who are doing both." [Interview participant 18]

"My predicament was I got placed between a rock and a hard place. ... My decision to quit was because I applied to the College for a three month extension on that maternity leave and they declined it. Basically it was me coming back [to Australia] with my two small children ..., I had no family support here at all ... to do a very surgical job ..., leaving my husband four months without seeing his children The reason I quit training was I was put in a position where one of us had to quit our jobs because the College wouldn't allow me to have that three months extra of maternity leave. ... I would have never have thought of quitting the training programme, I loved being a surgical registrar. I loved my job, yes it was hard and so difficult with two small children." [Interview participant 19]

A feeling of helplessness and despondency in the face of requirements that appeared to be unobtainable was conveyed.

"I really got the impression once I was there that it is this mentality of we don't care how much it costs you, we don't care what personal life you've got we just want you to essentially become our complete slave and just continually jump through hoops, nothing is ever going to be good enough. That became obvious early on. I being female wanted to have a family and a life outside of work. I realised early on that I would either have to give them my life or destroy my personal life." [Interview participant 18]

In terms of flexibility, a consistent discussion point was the apparent lack of flexibility in the surgical training programme. For example, there was a common perception that part-time training was not a possibility.

The whole concept of part-time training, they say it's an option because legally they have to. When I enquired about part-time training the response that I got was if you can figure it out you can do it. It was almost like you were the one dumb enough to have a baby on the programme, you deal with the consequence.

INTERVIEW PARTICIPANT 10



This lack of flexibility at specialty board level was viewed as being capricious.

"I got the impression from my particular Board that they moved us around deliberately to stress us out and to sort the sheep from the goats approach. My suspicion was that it was vindictive although I don't have any proof of that. It certainly was a total disregard for issues around family. ... what I was told was the Board allocations are made predominantly on training needs and attributes of training locations but we are unable to reveal to you what our assessment is of your training needs or the training attributes of the various locations and certainly not the trainee needs of other trainees. We are sending you to [capital city] because it's a perfect match for you but we can't tell you why so then you can't really argue a case because it's a mystery." [Interview participant 2]

More generally, examples were provided of the perception that family life in general is incompatible with a surgical career.

"I didn't see in the longer term that my marriage and my surgical career would co-exist so I made a choice to make a change." [Interview participant 22]

And for those who had attempted to raise a family during surgical training, this was reported in unfavourable terms.

"It was very restrictive, as long as it was in six month blocks they were happy. There is so much on-call and stuff you aren't going to work if it's not going to count towards your training. I went back with the attitude of "I'll do this six month rotation and just see how it goes". It went disastrously. I sat down with my husband and said I don't want to do this for the rest of my life. I was missing every important thing in my baby's life. I am a mother first and a surgeon second. I had spent 12 months at home being a mum. It's hard to explain this to the College of Surgeons, who are a group of men, that I'm not that kind of woman that wants to pump out four babies and stay at home and look after them and take long maternity leave. I ended up getting bored out of my mind in that 6 months and ended up doing private assisting as I was going around the bend. I wanted to be at work but didn't want to neglect my family which is what happened when I came back after 6 months. It's all of nothing with them. When I tried to explore options like part-time training or even reducing on-call or anything, it was basically your problem. There is no system in place." [Interview participant 18]

When participants experienced illness and stress they also reported a lack of flexibility in response to their individual needs.

"You have to finish training within nine years of starting. That fact forced my withdrawal, I was in hospital and clearly wasn't going to get any better quickly ... there was no leeway given." [Interview participant 5]

Respondents also described circumstances in which they lacked appropriate levels of clinical supervision. Associated with this was a culture in which they perceived that they were not able to ask for help even when patient safety was their driver and even when the situation was not aligned with the formal clinical arrangements in place.

"Not having the experience and being a junior trainee I requested the support from the consultant who was on-call. I had issues in getting support and direction and acknowledgment of my efforts to try and manage the patient. I needed senior support and the surgeon to come in and actually operate on the patient. I didn't have a lot of support from the consultants that I had been on placement with and felt a lack of senior support. For me to manage a patient at that hospital was not a very good experience. It could have compromised patient care." [Interview participant 12]

Some of [the patients] were a bit more complex than I was comfortable with dealing with. This is me four or five months into my [other specialty] surgical training. ... I rang the consultant who was on-call for that weekend and said to him this is what I had on and I am going to need some supervision and he said to me 'I'm going on a [weekend away] ... so you'll have to ring around and find another consultant to help you out' even though he was the one on the roster that was to be on-call for me. ... I managed to find a consultant that was happy to come in and support me for those procedures but that was the last straw. I just thought I am not being trained, I had no supervision, I'm out of my depth. It should be obvious to blind Harry out on the street that you can't leave a registrar that's four months into [other specialty] training to operate on these patients on a Friday night without any consultant supervision. The consultant seemed completely unconcerned that that was going to happen ... it was left to me to find other consultant that may or may not be in-town and may or may not be operating in another hospital and try and get one to come in and supervise me for these patients.

INTERVIEW PARTICIPANT 8



In addition to examples of poor clinical supervision, respondents experienced a paucity of positive role models.

"It's basically almost that they pride themselves on the fact that you have to sacrifice everything to be a surgeon and it's not true. To be a good surgeon you just have to be technically adept and just technically good. You don't have to be operating for hours on end to be classed as a good surgeon. A good surgeon is someone that can go into an operation, do it well and provide patient support and care afterwards. They're basically going on with this misconception that the best surgeons are those that sacrifice their entire life for it. They're not the best surgeons, they're just the people who have nothing else happening. I don't think it's a healthy personality and I don't think it is something that should be encouraged." [Interview participant 18]

"... I didn't see a lot of happy consultants while I worked there" [Interview participant 21]

Participants described many cases of poor role modelling of professional behaviour and senior colleagues who were unable to demonstrate a good work-life balance.

"... one of my bosses was admitted as a patient himself. He had some arrhythmia in his heart or something, nothing major but he had to stay in overnight. ... in the morning when we rocked up to work we knew that he had been admitted the night before. We start the ward round by going in and seeing him to make sure he's alright. When we got down to the ward we found out he had self-discharged not to go home but to go upstairs and give a tutorial to the interns which is his weekly dedication at that time. I thought what's wrong here, what's wrong with this guy, you didn't even go home. It's all well and good to think that we are going to be different to those 10 or 20 years ahead of us but we are going on the same path so we can't be that much different as hard as you try. There is a system there where people come out the other end and I wasn't liking what I was seeing. I didn't look up to, not that I didn't look up to them professionally, I respect them a hell of a lot for what they do. ... I didn't want any of their lifestyles." [Interview participant 20]

A culture of bullying and public humiliation was experienced and typically described.

... [consultant surgeon] was such an unbearable character and he would just dress me down in front of large groups of people. He absolutely went for me. I grew up in a surgical family so I knew the game but I just thought 'do I really need this?' That coincided with me becoming completely exhausted.

INTERVIEW PARTICIPANT 17

"... it [the surgical culture] is well known and is the only reason why I left. I had absolutely no other reason. I had no kids, I didn't have a partner, I had social supports, I was studying, and I was doing academically well and was doing well in theatre. The reason was just the continuing bullying, belittling and condescending culture of this speciality and it continually decreased my confidence. I am a person that graduated from medical school with distinction. I had high self-esteem and confidence - but appropriate. I knew what I knew and I was aware what I lacked but my years in that specialty gradually made my confidence decrease because of the continuous belittling. That culture is very strong and it needs to change." [Interview participant 13]

The culture of bullying was sometimes manifested as exerting undue pressure on the participant to leave training – either directly or indirectly by making life so unpleasant that continuing was intolerable.

"I felt that that [poor clinical outcome] just carried on and haunted me for the rest of my surgical career and then when I started at my very final placement for the year I was told, the week that I started there, by one of the senior surgeons that they had placed me there because the College wanted me out and they had been tasked with the job of getting me out of the programme. I don't think I had any option at the end of that year to resign otherwise they would have not fired me but I felt they would have terminated my training." [Interview participant 7]

"... she started abusing me when she got into the hospital, she abused me throughout the entire surgery, she abused me afterwards and then sent an email out to all the surgeons telling them I was a liar and I couldn't be trusted. It was all on the basis of some confusion. I had thought I had clarified with her that she wanted me to call when the patient had arrived, that is why I did the extra phone call. As a result of that for the rest of the year she either didn't speak to me or would send out nasty emails about any mistake that I made because in her opinion I was unsuitable for [surgical specialty] training simply because of some confusion. That was unfortunately a typical example of dealing with that consultant. Anything that she saw as unsatisfactory to herself was the basis to try and boot me out of the training programme. ... You couldn't do anything to dig yourself out of the hole." [Interview participant 10]



The examples of bullying given above were made by male and female respondents although sexist comments were exclusively mentioned by female respondents in this cohort.

“... he said ‘you are a stupid woman’ and that was in front of everyone. The rest laughed and thought it was a funny joke. I don’t remember what my reaction was but it just stuck in my head. His behaviour continued like this. I went and spoke with the Head of Training at the time to ask what I should do. He said to me ‘you are not the only person, we’ve had other female trainees treated like that by him, we are aware of the problem, you just need to understand that it’s not personal it’s just his way’ so basically ‘put up with it, suck it up’. You know this problem pre-existed, it’s not the first time and you are Training Director and you are telling me to put up with it. If that is the Head of Training telling me that you think ‘ok I’ll just have to put up with it’. I did for a long time.” [Interview participant 13]

...we think you need to do another six months ... with no other explanation why. I just knew that this was covered as soft aggression. If you don’t agree with us we will extend your training. I just thought ‘oh gosh, he should have yelled at me in front of the others and I should have just said sorry, sorry, sorry and carried on.’ I made a mistake that day by defending myself. It carried on.

INTERVIEW PARTICIPANT 13

Gender could be a complex issue for participants and was reported that being a specific gender could occasionally confer benefits as in the following example of a participant experiencing an intimidating surgical boss.

“I was told to bring my knitting needles next time if I didn’t know things. If I don’t know the answer I should just bring my knitting needles and sit in the corner next time. I was called a da Vinci for about the first six weeks ... because I had answered two of the first anatomical questions correctly but they were the easy ones obviously. After that I got into strife and couldn’t answer any further questions and so my nickname for the next well six months ... was da Vinci because I was such a ‘master of anatomy’. ... It was only about the first six weeks that he really tried to humiliate us. Once we felt small and useless he eased up a bit but would still pull it out every now and again to remind us we were useless. There was one other trainee. Part of the problem ... was there was [sic] only two trainees. It was a very small hospital and we were under the thumb the whole time. ... I routinely ate my lunch in the women’s bathroom because we weren’t really allowed to sit down and eat so I would just eat my lunch in the bathroom. If we were caught in the tearoom he would come in and say ‘do we have time for tea?’ or ‘I’m glad someone has got time to eat’ those kind of comments. ... I would just eat in the bathroom. I was lucky because I was a girl and my boss was a boy. My male colleague didn’t have that privilege. If he wanted to eat he would just have to cop the comments and then the afternoon was spent battering constantly, grumpiness, not talking or making more inappropriate comments. He would constantly talk about other registrars whom he had ‘broken’ or who had quit training or ‘this is nothing compared to such and such’ or that kind of behaviour.” [Interview participant 14]

The impact on trainees cited were significant – mental health issues were significant from major depression and anxiety to burnout symptoms.

The perception of the College itself as a barrier to progress was common. It led to participants feeling as though they were in an adversarial position with the College systems.

“... From the local network everyone was supportive and fantastic and then you hit the College and it was like a road block. It was that I was to deal with it and it was my problem. It was just the standard College mentality of you are nothing but a little trainee. ... My whole impression of the College of Surgeons is that trainees are nothing, they are nobody. ... By the time I left the programme there was this us versus them, the College versus the trainees and the consultants.” [Interview participant 18]

“... time and time again it was a thing of you’ve just got to put up with this or you should count yourself lucky that you are doing surgical training and everyone around you and everyone in your family has got to count themselves lucky that you’re doing surgical training and you just need to learn to put up with it.” [Interview participant 22]



Participants also reported a perception that College decisions regarding training progression were not based on merit.

“I felt that it was not very fair and you could see that comparing myself to other trainees you’ve got the same CV, the same qualifications and there is favouritism and I felt that it was not fair at all. For me to have a successful and dynamic career, to be in an environment where it is based on favouritism, who you know, whether you are liked or not based on personality and not based on skills or your qualifications that was a big reason why I decided to leave surgical training.” [Interview participant 12]


There was also a report of discrepancies between informal and formal assessments and feedback.

“ ... actually we were just being nice on that paper trail because we thought she was going to do an extra six months of voluntary training. It was all very confusing. ...” [Interview participant 2]

Such experiences described above compared unfavourably with some subsequent training experiences in other specialties.

“ ... being a radiology trainee where I am treated like a colleague essentially. They all have been there and been trainees. ...I ... had another baby and it’s quite easy in Radiology to stay. ... With other training programmes you are part of the team. You still have to do the requirements, you still have to be good enough and you still have to pass exams. It’s an entirely different attitude, it’s a very supportive environment. ” [Interview participant 18]





What is it like to leave
surgical training?





WHAT IS IT LIKE TO LEAVE TRAINING?

SURVEY COMMENTARY

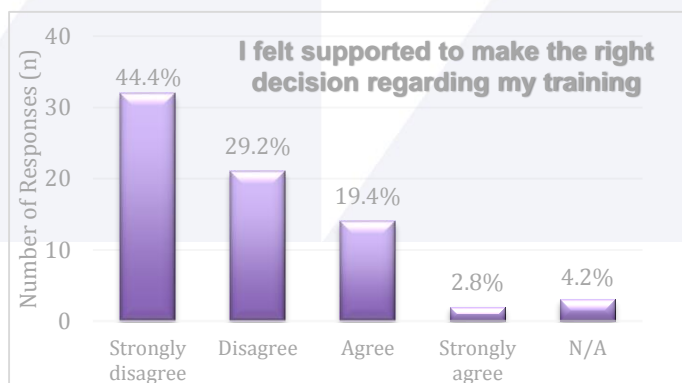
Trainees who have had the experience of withdrawal from training are well-placed to report on their perceptions of this experience. Doing so may enable practical improvements to be made. Survey participants were asked to rate their level of agreement to questions regarding the withdrawal process.

Almost two thirds of respondents disagreed that their interactions with supervisors around withdrawal were positive. There were between group differences for those who were undergoing general and other specialty training. The group in general surgical training were more likely to be in agreement that the interactions they had with RACS supervisors around withdrawal were positive.

Almost 90% of respondents stated that they had initiated the withdrawal process themselves. There were between group differences for those who were undergoing general and other specialty training. The group in general surgical training were more likely to be in agreement that they initiated the withdrawal process.

If I had a more supportive training environment and a bit more sense of work-life balance then I wouldn't have got burnt out. If RACS supervisors had been supportive when I expressed thoughts about withdrawing then maybe I could have ... resolved my concerns and continued in training. Rather, when I expressed concerns the attitude was "if you don't like it, get out".

SURVEY PARTICIPANT 12



Very few respondents had been asked to consider withdrawal by a supervisor colleague. Similarly, very few respondents had been asked to consider withdrawal by their Specialty Board. Again there were between group differences for those who were undergoing general and other surgical training. The group in general surgical training were less likely to be in agreement that they were asked to consider withdrawal from the training programme by the Specialty Board.

Three quarters of respondents stated that they hadn't felt supported to make the right decision regarding their training. Commonly, a sense of isolation from the College and the training programme was evident.

Whilst less polarised, over half the respondents stated that they disagreed or strongly disagreed that RACS had managed their withdrawal sensitively.

A thematic analysis was undertaken of the seventy free text responses describing what, if anything, could have been done to prevent withdrawal from training. Suggestions from survey respondents to improve trainee attrition include:

- Increased flexibility in training: improved leave and formal interruption arrangements, provision and acceptance of part-time work.
- More supportive training environment to improve the balance of clinical, training and outside of work responsibilities (work/life balance).



- Amendments to the training placement allocation process. Suggestions included reduction in the number of training placements required to increase training stability, placements assigned at commencement of training to assist with training planning and increased transparency around the placement allocation process.
- Improved formal and informal support systems for trainees at both the local site and College level. Suggestions included access to an independent party to discuss training options.
- Provision of a training culture free of bullying, discrimination and sexual harassment.
- Supervisor accountability: systems and processes in place to ensure appropriate training for all trainees across training sites.
- Improved fairness and transparency around the training selection and assessment processes across the surgical specialties.
- Improved communication regarding training requirements from the College to both trainees and supervisors/trainers.
- Increased access to centralised and local training in technical competence and non-clinical skills throughout training.

A thematic analysis of the fifty-one additional comments regarding withdrawing from the training programme was undertaken.

Approximately a quarter of survey participants expressed regret and disappointment about leaving surgical training. The decision to leave was one that was not made lightly or overnight and predominantly due to cumulative negative experiences.

Approximately 40% of survey respondents felt unsupported during training which caused many participants to become despondent with surgery as a career choice.

The majority of survey respondents reported that surgical training had a significant impact on them in their future careers and endeavors.

The impact of surgical training and the process of leaving was further explored with interview participants.

It was not the work that drove me to withdrawal, it was the unsupportive culture, the bullying, the lack of care that consultants had for their trainees. Senior trainees mimicked this by flogging junior trainees on the roster and belittling them when they asked for help. The high pressure work I enjoyed. I was good with my hands, passed my exams and received good feedback. The work wasn't the problem, it was the people. I didn't want to end up like them.

SURVEY PARTICIPANT 13





What is the overall
experience of training?





WHAT IS THE OVERALL EXPERIENCE OF TRAINING?

SUMMARY

We asked the participants to evaluate the overall experience of their time in training. This included a broader and comprehensive look at all aspects of their educational programme; assessment, course evaluation, course requirements, placements, administration and governance. Having a system in place to routinely collect and review students' experiences of all components of a professional programme is standard good practice and respondents engaged enthusiastically and generously with the requests for information. The insights they provided were considered and focussed on practical and achievable improvements. In this first section we report on the more general aspects of training experience and what was considered to constitute positive and negative training experiences.

SURVEY COMMENTARY

The survey collected participant evaluations of their overall training experience.

Almost 60% of survey respondents were not satisfied with the overall training programme. This is a high level of dissatisfaction. There were multiple aspects of the training programme that contributed to withdrawal by survey participants and these reasons are expanded on within other sections of this report.



Half the survey respondents were dissatisfied with the overall workload for training (including assessment and placement requirements). There were between group differences for those who were undergoing general surgical training and other surgical specialty training. General surgical trainees were more likely to be in agreement that they were satisfied with the overall workload for training. The workload within other surgical specialty training merits review and bringing to parity with general

surgical training.

Only 37.5% of survey participants reported a satisfactory balance between clinical and training activities. Over half thought that their clinical workload was not manageable.

The majority of respondents agreed that the level of responsibility they were given during training was appropriate.

This finding alone suggests that this group was generally highly capable in the area of clinical competence. Again there were between group differences for those who were undergoing general surgical training and other surgical training. The group in general surgical training were more likely to be in agreement that they were given an appropriate level of responsibility. Putting resource into investigating trainee workload and levels of responsibility in the other surgical specialty areas should be considered.

One of my placements I received good clinical teaching and supervision/teaching with respect to operating, that was appropriate to my stage of training. This was very early in my training and these same supervisors have continued to be strong mentors thereafter. The clarity of structure / requirements for training and exams [were positive].

SURVEY RESPONDENT 39

Opinion was fairly evenly divided regarding the amount of on-call expected with slightly less than half agreeing and disagreeing on this subject. Approximately a quarter



of survey participants did suggest that improvements to on-call and rostering systems would have prevented withdrawal.

Overall there is a higher level of dissatisfaction from trainees who withdraw from other surgical training than general training regarding an appropriate workload and level of responsibility. A rebalance of workload according to level of training across all surgical specialties may be required.

A thematic analysis of sixty-three responses describing the most positive aspect(s) of training was undertaken. As expected with this study cohort, there were some participants that were dissatisfied with their surgical training experience and were open about not having a positive experience to share. Of those that did respond with positive aspects, the responses were varied and included descriptions of the following themes (in frequency order):

- Supervisors who provided positive supervision with whom participants felt their surgical abilities improved.
- Colleagues who demonstrated team work and collaboration appropriately.
- Knowledge and skills gained during surgical training that are applicable and transferable in their chosen subsequent career path(s).
- Training courses and workshops run by the College and specific local teaching sessions.
- Accessibility of information from the College regarding training and assessment requirements.
- Interactions with patients.

Survey participants were asked if they had any suggestions to improve training overall. A thematic analysis of sixty-three responses describing what could have been done to improve training was undertaken. Many survey participants shared comparisons with training experiences in their chosen career paths. The suggestions for improvements to training were very similar to solutions put forward by respondents to prevent withdrawal. Themes are summarized as follows (in frequency order):

- Increased levels of supervision and guidance provided throughout training. Survey respondents suggested that to successfully advance their technical and non-technical abilities in surgery, all colleagues in the department need to not only be willing but play an active role in appropriate training of juniors.
- Changes to the rostering system to increase flexibility in training. This was suggested to enable part-time training if required and reduced on-call at specific times during training for example at exam preparation time. There were specific placements reported as having unsafe rostering practices. If not already done so, trainee feedback should be included as part of placement accreditation processes.
- Provision of working environments that promote learning in a safe culture.
- Development of stronger mentoring and networking pathways for both trainees and supervisors. In addition, the availability of a confidential support system to discuss training issues.
- Structural changes to the training programme including improvements to the placement allocation system.
- Increased transparency with all College processes, in particular workplace-based assessments, trainee selection and leadership appointment.
- Training for supervisors on aspects of their role including provision of feedback, teaching methods for individual learners and managing underperformance.
- The College to assist individual sites with balancing the delivery of training requirements and service provision for improved trainee workload and work/life balance overall.
- Improvement to the management and responsiveness to inappropriate supervision and training.
- Improvements to the remediation process with central College coordination for increased consistency across the surgical specialties.

Further details of survey respondent evaluations of the training programme overall are available in *Appendix F: Survey Analysis*.

Provide an independent mentor that has NO relationship whatsoever with any consultant the trainee is working under and give that mentor power to advocate directly with RACS to assist with problems that trainee may be having. The issue of independence and confidentiality is paramount otherwise trainees will NOT report issues because of the absolutely real possibility of retribution.

SURVEY RESPONDENT 46





What is the experience
of assessment in
surgical training?





WHAT IS THE EXPERIENCE OF ASSESSMENT IN SURGICAL TRAINING?

SUMMARY ON ASSESSMENT

In all educational programmes across the world and across all levels and disciplines, assessment occupies a central place in the thoughts and energies of students. It was therefore somewhat surprising that this group of survey respondents and interview participants had so little to say about their assessments within the surgical training programme. Overall, any exam concerns were considerably overshadowed for them by their concerns related to the negative experiences in the clinical milieu.

This is not to suggest that there is no room to continue to make improvements in training assessments. This is an area of educational practice which is currently making large advancements particularly in the area of workplace-based assessments.

This study provides a clear focus for areas of improvement to assessment. These are pinpointed on two particular issues:

- ensuring that formal assessments (exams) are an authentic reflection of the knowledge, skills and abilities that trainees require for specialist surgical practice
- that the systems and practices to provide feedback on workplace-based assessments (including all placement feedback and assessments) genuinely reflect the trainee's surgical capability.

Some concerns about fairness, equity and transparency are dealt with in other areas of this report.

It should be noted that any recommendations made around exams are limited due to the small numbers able to comment from personal experience. In particular, no commentary can be provided on the Fellowship Examination.

SURVEY COMMENTARY ON ASSESSMENT

There is a perception that trainees who withdraw from training predominantly do so as the result of unsuccessful assessment outcomes or anticipated remedial arrangements. Experiences with the surgical examinations were explored with survey participants and, in general, this was a group who were progressing effectively and efficiently through exam processes.

60% of survey respondents indicated that they were satisfied with their experiences with the Generic Surgical Sciences Exam (GSSE). This is considered to represent a high level of satisfaction for a high stakes professional assessment.

Similarly, only 14% of survey respondents were dissatisfied with their experiences with specialty specific Surgical Science Examinations (SSE) with the highest level of 'strongly disagree' reported across the assessment questions within the survey. There were no significant differences in experiences reported between general and other surgical specialty groups.

Approximately 50% of respondents were satisfied with their experience of the Clinical Examination.

Only one respondent indicated their level of satisfaction with the Fellowship Examination. The respondent was unsatisfied with their experience. A meaningful interpretation of survey participant perception to the level of satisfaction with the Fellowship Examination based on the number of responses received is not possible. The response is probably due to an unsuccessful exam outcome.

Respondents were asked to report on the number of attempts and the outcome of the examinations in the surgical training programme.



The number of attempts at the GSSE reported by survey participants ranged from zero to four attempts. 60% of respondents had attempted the GSSE one or more times. Of the survey participants that responded to this question, 91.5% reported they had passed this examination.

45% of respondents reported they had attempted the SSE one or more times. Of the survey participants that responded to this question, 75% reported they had a successful examination outcome. There were no significant differences reported between general and other surgical specialty groups.

The average number of attempts at the Clinical Examination was less compared to the GSSE and SSE and can be expected given the nature of this assessment. Just less than half of the respondents reported undertaking one attempt at the examination and of those that responded to this question 92.1% indicated a successful examination outcome. There was a difference in the response to experiences in the Clinical Examination between those who took an interruption from training and those who did not. The group who took an interruption from training had attempted the Clinical Examination on significantly more occasions than the group who hadn't interrupted from training. All women respondents who sat the Clinical Examination were successful. This accounted for a significant difference between men and women for this item.

Approximately 80% of survey participants had not attempted the Fellowship Examination. The one respondent that indicated they had attempted the Fellowship Examination reported that after the second attempt they were yet to be successful in this examination.

As mentioned previously, data from this study is self-reported and subject to limitations. The findings in this section of the survey do demonstrate that examination experience does not contribute to the reason for withdrawal. And that those who withdraw cannot be perceived to be failing College assessments.

Collection of data on experiences with all training programme assessments for both current trainees and those that withdraw is recommended to further explore trainee perceptions.

See *Appendix F Survey Analysis* for detailed analysis of survey responses to the assessment items.



INTERVIEW INSIGHTS ON ASSESSMENT

In general participants were either phlegmatic or slightly positive regarding their College examination experiences.

“Exams are exams. Exams are hard and we all stress about exams and that is the nature of the beast. The College does run a reasonably good exam system.” [Interview participant 1]

“I thought my primary was completely acceptable. I didn’t think it was too hard, I didn’t think it was too easy.” [Interview participant 19]

I actually think the assessments were quite good. I think it’s good you have a mid-term progress report, the formal discussion with your supervisor about how you are going. Also the direct observation one they have where you do a procedure or operation and they grade you, I think that is demonstrative. I don’t have a particular problem with the assessments.

INTERVIEW PARTICIPANT 3

And in terms of the overall assessment portfolio, interview participants had very little commentary.

“Assessment wise I think it wasn’t too bad to be honest.”
[Interview participant 14]

Where respondents tended to focus their contributions was on assessments in the clinical environment. A number of issues and criticisms arose about the experience of being assessed in the workplace. These included a perceived lack of objectivity. It was considered that consultants made their assessment decisions on non-documented attributes. Of particular concern were comments around personality differences appearing to be used as assessment criteria and that these initial assessments were somehow conveyed within the surgical community and could give rise to enduring negative perceptions about the trainee. Whilst objectivity is a major challenge in workplace-based

assessments of any nature, there appeared to be a disproportionate level of concern regarding this matter. In a context in which discrimination is reported, this must be addressed.

“It needs to be more independent. I felt that it was completely personality driven. You were either liked or you weren’t liked. I felt that I was tarred with a brush right from the start and that was never ever going to change.” [Interview participant 7]

Participants focussed on issues that needed to be improved and gave particularly open suggestions about their desire for constructive and corrective feedback. This was different to their common experiences and improving feedback needs to be a training programme priority. What is recorded as an assessment decision should also be communicated to the trainee. There should be no discrepancies between assessment outcomes and the perception of the trainee’s ability as a surgeon.

“There wasn’t really a robust in-depth discussion on say these are the areas where you could potentially work on to improve and working on specific strategies. For example assessments for interns, you come up with performance improvement plan, articulate key issues and come up with specific strategies and a timeframe. That wasn’t the case when I went through the assessment process. Maybe there wasn’t any glaring issues but it would have been nice to go into more depth, even focus on personal strengths and weaknesses. I am sure everyone can improve in some regard. Discussing opportunities to improve and then come up with a plan would make the process much more robust.” [Interview participant 1]

“... the way the assessment reports are done leaves the trainee in a very powerless position. Essentially the consultants can get together, can write whatever they like about you and like I said someone could send a nasty email and suddenly your report is going to go downhill. It puts all the power in the hands of a few people and takes it entirely away from the trainee. [Interview participant 10]

The following interview participant made particularly valid comments about the way in which feedback on assessment should be structured and provided in an honest and transparent manner.

“The assessments weren’t really the issue, it was more about the way they were presented and the ability to give your side of the story and give feedback and have an open two way discussion about the assessment. ...Raising any issues and having a two way street rather than ‘you did well on this one and didn’t do well on this one’. Have more of a discussion about ‘you didn’t score so well on this point so let’s look at why that is and have a look at what issues you were having, what issues



we were having, let's come up with a solution for that'. Assessments are all well and good and we need them. It's not just a number on page it's a formal proper two way communication about why the assessment is what it is." [Interview participant 8]

The matter of calibration for assessors was also given thoughtful consideration and recognised as a key component of successful and effective assessment in the workplace.

"Maybe if there was a system in place where the supervisor pays more attention to what you do and is trained to examine people or goes to a standardising workshop that teaches them what to look for and what the expectations are at the College." [Interview participant 16]

Participants described a perceived lack of content validity in assessments. That was, that they considered there to be a poor match between the nature and content of the assessment within the training programme and the skills and attributes that are needed to perform effectively in the clinical specialty. This needs to be addressed whilst still maintaining a balanced assessment load.

"I think that the 'Term Assessment' is very broad, ambiguous and actually doesn't end up being a useful tool for feedback or things to work on. ... I felt that the assessment process was just a rubber stamp to complete before you went onto your next term and it never really gave any good or specific feedback. There was an assessment where the supervisors assessed you doing a skill but it was just that, doing a skill and there were no benchmarks as to how you were to perform that skill, it was all very ambiguous and non-specific. ... I think with that if there were specific assessments of specific skills that were required then again it would put a bit of onus back on the supervisors and they had an actual responsibility to train you to complete these assessments rather than by hope and chance that you would be able to do it by the end of the term." [Interview participant 22]

Several different systems of assessment were described over the course of the interviews and it appeared from the interview participants that there were regular changes to exam and assessment requirements. These were not well understood (either what they were or the rationale for their implementation). Whilst it is difficult to engage with a dispersed trainee cohort this situation does suggest that more comprehensive communication and engagement with the trainee body about assessment changes would be beneficial. Also that any changes need to be communicated in a coordinated fashion providing a reasonable notification and transition period.

... The biggest thing they could change is to NOT change it so much. ... I don't think there is any third party looking at what's going on. The College gets a new head of whatever and they say let's make it better, let's change it and that's the kind of changes you get from year to year.

INTERVIEW PARTICIPANT 20


You never quite knew where you were at in terms of where you should be in your training. It wasn't until after some of my old supervisors had found out that I was leaving training that they made contact with me and had all said that I was one of the better trainees they ever had which was the first time I had that feedback or affirmation of how I was actually going..

INTERVIEW PARTICIPANT 22

I think that assessments should be performed independently and they should be done in a very structured manner rather than just the impression of the consultant. The other thing that I think with assessment is that where a problem comes up with assessment for example is they think a trainees surgical skills are still not strong enough then a programme should be put in place to improve it rather than just getting failed and then told you are obviously not up to scratch and not suited to this kind of training. It would be better to say oh ok you are junior, your surgical skills are still a bit rough, why don't we put you into a general surgery rotation for three or six months to try get your skills up. That would be a much more useful way to improve someone's skills rather than just saying you're not doing well and you're not suited. I think as a result of the current assessment processes the surgeons are losing a lot of people who may not meet the ideal model that they put in their heads of what it takes to be a good surgeon.

INTERVIEW PARTICIPANT 10





What is the experience
of clinical supervision &
mentoring in surgical
training?





WHAT IS THE EXPERIENCE OF CLINICAL SUPERVISION AND MENTORING?

SUMMARY ON SUPERVISION AND MENTORING

Supervision was a vexatious issue for participants in this study. In combination, the survey responses on this topic together with the alacrity with which interview participants could produce detailed and specific examples of poor supervision was alarming. This was closely linked to the surgical culture described in the summary provided of reasons for withdrawal from training.

Mentoring was spoken of as being a highly desirable mechanism to improve the experience of training. On close scrutiny, mentoring was generally viewed as the means to support the trainees through poor supervisory experiences rather than a means to improve their own abilities. Whilst the need for the support that mentoring can bring has total validity, it is not treating the actual problem created by ineffective and inappropriate supervisory experiences. Mentoring can provide support to deal with poor practice and help the trainee to develop strategies to deal with poor supervision. The trainees were not usually perceiving mentoring in a coaching framework.

An unacceptable culture in which supervision is practised requires strategies that are primarily focussed on the supervision itself rather than teaching trainees how to deal with this.

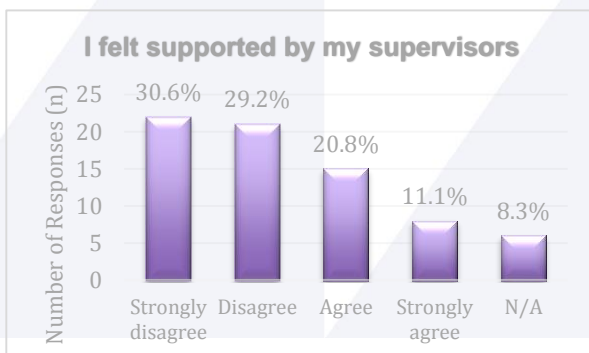
You need to put supervisors of training in place who actually care about trainee welfare. There should be access for training of these people in how to relate to trainees and their concerns.

SURVEY RESPONDENT 35

SURVEY COMMENTARY

A combination of high quality and consistent clinical supervision and effective mentoring can be considered critical to successful progress in clinical education. Survey participants were asked to rate their level of agreement to a number of questions regarding clinical supervision and mentoring.

Satisfaction with the amount of clinical supervision and support provided to survey participants was canvassed. Levels of agreement and disagreement with the amount of supervision and support provided clinically was fairly evenly distributed with 49% of respondents being dissatisfied and 43% of respondents being satisfied. There was a difference between the responses of the two groups of respondents who interrupted from training for less than 12 months or 12 months or more. The group who interrupted for 12 months or more reported a higher level of agreement that they were satisfied with the amount of clinical supervision / support provided. The reason for this between group difference is not immediately obvious.



Sixty per cent of survey respondents disagreed that they were supported by their supervisor(s) during training. Again, there was a difference between the responses of the two groups of respondents who interrupted from training for less than 12 months or 12 months or more. Similarly to above, it is not clear why this difference should exist. The group who interrupted for 12 months or more reported a higher level of agreement that they felt supported by their supervisor(s). There were also between group differences for those who were undergoing general surgical training

and other surgical specialty training. The group in general surgical training were more likely to be in agreement that they felt supported by their supervisor(s). Further exploration of trainee perceptions of supervision and appropriate support was undertaken during the interview phase.



Survey participants were asked for their opinion on the professionalism of supervisors. Almost 50% of respondents agreed that their supervisor(s) were professional. In an ideal situation a supervisor should always be viewed as demonstrating the highest levels of professionalism at all times. There were significant between group differences for those who were undergoing general surgical training and other surgical specialty training. The group in general surgical training were more likely to be in agreement that they found their supervisor(s) to be professional. The traits of both positive and negative supervisor were further explored at interview.

The responses to this section of the survey did highlight that participants who were undergoing other surgical specialty training were more likely to disagree that their supervisors were professional and supportive. Further investigation into potential differences in supervisor style between general and other surgical specialty branches of training is warranted on the basis of these findings.

Approximately 50% of survey respondents disagreed that the feedback they received from their supervisor(s) was helpful in planning their learning needs.

Similar to the opinion on whether feedback received from their supervisor(s) was helpful, 50% of respondents disagreed that feedback they received was done so in a timely manner.

During ... my SET2 year, consultants supervising me on individual rotations made me feel totally unsupported and if that had not been the case I think I would have probably continued. I didn't feel there was really anyone I could approach to discuss my concerns without fear of backlash and jeopardising my reputation.

SURVEY RESPONDENT 12

On the subject of receiving feedback from their supervisor(s), 11% of participants provided a 'not applicable' response possibly indicating that the majority of survey participants acknowledge that some form of feedback is provided by supervisors.

Although responses to the provision of feedback by supervisors were not polarised, an area for supervisors to be mindful of is the provision of feedback to all trainees that is both effective for learning and timely.

Survey participants were asked about feedback provided by colleagues. Opinion was fairly evenly divided regarding receiving appropriate feedback from colleagues with slightly

less than half agreeing and disagreeing on this subject.

Almost three quarters of respondents stated that they were not satisfied with the mentoring they received during their training. Commonly, the lack of appropriate mentors and role models to aspire to was evident in the survey responses and comments recorded.

For further detail of the analysis contributing to the commentary in this section please see *Appendix F: Survey Analysis*.



INTERVIEW INSIGHTS ON SUPERVISION

Interview participants were asked to describe both positive and negative supervisors from their experience in surgical training. They proved to be both gracious and fair in providing their balanced descriptions and willing to give credit when merited.

EXPERIENCES OF POSITIVE SUPERVISORS

In terms of what was viewed positively, there were several references to positive supervision occurring outside of large tertiary or teaching hospitals. Several examples of positive experience with supervision came from rural and smaller hospitals.

“In the country hospitals the supervisors were fantastic.” [Interview participant 18]

“In the peripheral hospitals you tend to get more supervision because it’s just them, you and a resident. It’s a very close approach to operations and any cases that come through the door. They were very positive.” [Interview participant 6]

And increasing age was not seen as a barrier to providing effective supervision with several interview participants referring to “... the really old surgeons” [Interview participant 18] in a positive light and in the following example.

“He was an older guy and close to retirement so had a lot of experience and had done thousands of surgeries in the past.” [Interview participant 8]

Perhaps too frequently, the positive examples that were given were those that demonstrated an *absence* of a negative characteristic or attribute that the trainee had experienced routinely in other areas. This sometimes was expressed with surprise that these positive examples could be present in surgical training because they were so different to what the participant had experienced elsewhere. Some examples included an absence of having preconceptions (for example about women’s ability or suitability for a surgical career) or the absence of a laissez faire approach to supervision in theatre or the absence of being seen as ‘an inconvenience’ to the surgeon or the department as a whole.

Several illustrative examples are provided here.

From a personality side of things they weren’t cruel, they were there to support you and not to criticize but to point you in the right direction when you need it.

INTERVIEW PARTICIPANT 21

“He didn’t come with any preconceptions as well. I felt that because I was a young female from [major city] that a couple of the surgeons there judged me a little bit when I first got there. They treated me fairly and at the end of the year they really said very respectful things about me for the College. ... He was very supportive, encouraging, non-judgemental about other things like I’m a woman and that kind of thing.” [Interview participant 3]

“He was very good and the reason he was very good was because he wouldn’t just say: ‘This is your list go ahead and I’ll be in the coffee room if you need me.’ He would actually scrub up with me. We’d see the patients first beforehand together. I’d talk to them and he would be there with me. We’d go through their histories together while doing the surgery. He would stand at my shoulder while I was doing the surgery. He would let me do the surgery until I felt uncomfortable or felt that I had gone as far as I could. He would either talk me through the next bit or take over. He would be right there with me in theatre and would talk about the surgery all the time and he’d be describing what I’m seeing. He’d be telling me different techniques I could use. He’d be telling me different complications that may occur. I felt that I was very supported and I felt like if there was any problem at any point he was right there to help out.” [Interview participant 8]



I felt supported when I was given enough rope to try things but knew that they wouldn't crucify me if I made a mistake. [surgeon known to participant] who is 70 never ever in his surgical career lost his temper with a junior, it's just unprofessional. We are all trying to work in a small space with high stress, it's just self-indulgent.

INTERVIEW PARTICIPANT 17

"... was lovely, had a real teaching focus, didn't humiliate me, talked to me like I was a person those kind of things. He asked me about my weekend, ... you know he was the only one that would do that." [Interview participant 14]

"We discussed at the start of the term where he expected I should be in terms of procedures I should be performing by the end of the term and that was something that we were both able to work towards. That was very positive and encouraging. I felt that that supervisor had a great deal of trust in me. In response to that I felt that I was able to perform better and fulfil that trust as opposed to constantly trying to avoid being an inconvenience to somebody. That supervisor was very positive because we were both working towards the goal of my training and took personal interest in where I would be by the end of the term." [Interview participant 22]

In particular there were examples provided where it was the absence of unprofessional behaviour in supervisors that was described as the most positive experience of supervision during training.

Providing teaching and being willing and able to adapt and refine teaching to the level of the trainee whilst still providing encouragement and motivation to develop and grow were all seen as being highly positive attributes in supervisors. Supervisors who also reinforced that needing teaching as a trainee is legitimate were also viewed positively.

"He was really nice, he was a little bit scary but that was fine and I completely support that, he was really cool, really supportive, insightful and gave us lots of surgical time. He worked us reasonably hard but was also really understanding of what we were trying to do ... He would teach us and expect us to be good but he would also teach us if we got it wrong which is what you want when you do surgery. You don't want to be mediocre but you need to be shown. You can't expect a lot of things from someone that has never done it or isn't experienced and not show them". [Interview participant 17]

Even if I made mistakes she would be like 'this is how you do it next time'. She would actually give feedback that was actually useful rather than just shouting at you. To be honest I never saw her shout at any registrar. I thought she gave feedback constructively and there was no screaming or tantrums that you saw with the other consultants.

INTERVIEW PARTICIPANT 10

In terms of clinical supervision, one of the most favourably described situations was the supervisor who graded the level of supervision they provided in accordance with the trainees ability and again moving the trainee on progressively as they demonstrated their capability.

"In the first rotation that I did in the smaller hospital there was two surgeons in particular who were very supportive and appreciated that I was keen to expand my skills and that I wanted to choose surgery as a career path. They did everything in their power to help me including extra time in the operating room, allowing me to be a little bit more independent so that I felt a little bit more confident." [Interview participant 11]



Unsurprisingly perhaps, positive supervisors were respectful to trainees and also spent time building the personal relationship with the trainee and taking an interest in their goals and progress in the training programme.

“Always if someone takes the time. It doesn’t take a lot of time ... it takes half a minute to get to know someone and what their experience is and where their interest lies before you demand certain things of people. Where have you trained, what have you done, what’s your experience, what are you comfortable doing, what do you need help with ...” [Interview participant 20]

“I felt respected and I felt like I was a valued member of the team. Communication was at a collegial level rather than from a senior to a junior allowed me to behave in a manner that was I guess developing my surgical skills and decision making and developing me as a surgeon.” [Interview participant 7]

“He realised what stage I was at in my [other surgical specialty] training. He was able to discuss things with me at a very junior level. He was able to teach me the basics of [other surgical specialty], the very basic techniques and I enjoyed that. He was interested in me and interested what I was doing.” [Interview participant 5]

And finally, for positive attributes, trainees mentioned the respect that ensued from the supervisor being a good clinician and working compassionately with patients and effectively in the healthcare team environment.

“His passion for surgery was infectious. He was young and fun and never got angry and just really good to work for [Example 1] ... He was a lovely guy, he was senior in the College and very supportive and a fantastic technician and brilliant surgeon. He was really good in theatre. He would take the time to show me what he was doing, how he was doing it, tips, the do’s and the don’ts.[Example 2]” [Interview participant 17]

“They are kind to their patients, kind to their team, have a genuine interest in nurses, orderlies, trainees, they just have a genuine interest in everyone. There is respect and they are very good listeners, they are doers, they are just not bullies.” [Interview participant 13]



NEGATIVE EXPERIENCES OF SUPERVISORS

Unfortunately, examples of negative experiences of supervision were readily available. These are categorised in themes in this section with illustrative examples provided.

Supervisors were viewed unfavourably if they failed to take any notice of the trainee or demonstrate any interest in their training needs. This was attributed on occasion to more senior staff.

"I found that a couple of the older bosses didn't pay me any attention I suppose. They didn't really say hello to me when they saw me on the ward or in theatre. I felt that in a way they were even too high up for me to even talk to or approach. In a way the consequence of that was they didn't teach me anything really or engage with me. ... I was in a very junior position [so] I felt hesitant to talk to them or ask questions. I found that when I did they quickly dismissed me. I got the feeling they didn't really want me there and I wasn't welcome." [Interview participant 3]

Sometimes the trainee felt as though their contribution to the clinical team was not valued and that they were treated as a 'number' rather than as an individual.

"... the other units that I felt less valuable to my development just treated me as if I was a number on their roster, my opinions didn't matter. I did my after hours, I did my time there and that just meant that they didn't have to be in doing after-hours. There was no treating me as a colleague." [Interview participant 7]

There were other examples where supervisors showed a lack of willingness to allow trainees to have experience and a lack of an individualised approach to training and trainee ability.

"... Another supervisor, even though by that stage I had done a couple of terms and was becoming more competent in what I was doing, he had a preconception of what someone at my level should and would be able to do which was very basic. He was not willing to progress beyond that. I spent six months with that surgeon basically watching them operate and holding retractors for them." [Interview participant 22]

Supervisors who either trivialised the assessments or demonstrated a lack of engagement with the College assessment process were viewed in a negative light by trainees participating in the interview process.

"... felt the supervision forms I had they saw as a tick box exercise and didn't dwell on reasons behind things. They just wanted to get it out of the road. It didn't take very long and there wasn't any substance to it. There was no praise or positive support to what I was doing. There was no acknowledgement of the work that I was doing. Equally when I scored low there was no reason given for that. As I said before there was no effort made to why I scored low." [Interview participant 5]

When you are on-call having a supervisor look at you on Friday knowing they are on-call with you all weekend going 'I hope I am not going to hear from you all weekend, I have a date scheduled on my yacht' that kind of thing. You are then always in the back of your head going I can't call you now because you are just going to think I'm an idiot and you are going to be pissed off because I am ruining your weekend. You are going to make decisions without that support and you are going to make stupid decisions. That's where you get bad outcomes. Trying to fluster you while you are operating, to me why bother. I can't see it as a helpful thing in surgical training to be purposely unsupportive to see if they can get through it.

INTERVIEW PARTICIPANT 19



Detailed examples were provided where the trainee perceived a lack of clinical supervision when they identified that it was required. They also described their level of concern that this may impact unfavourably on patient safety.

"I'll describe a case. There was a gentlemen that I needed to put an SPC (suprapubic catheter) in for. He had previous abdominal surgery therefore putting an SPC is always risky because they might have adhesions ... so there is a risk that you might hit other organs when you try and put a catheter ... into the bladder. The surgery had to be done, it couldn't be postponed. I had done this procedure many times before but not on a patient with these pre-existing problems. The supervisor at the time was somewhere else in the hospital. I rang him and described the issues and he said "oh look you'll be fine, just go ahead and do it" which sent a shiver. I was very uncomfortable but he was my supervisor and said go ahead and do it so I did. Luckily nothing happened to the patient and the procedure went smoothly and the patient was able to be discharged from hospital a couple of days later. It was a very nerve racking experience and I lay awake most of that evening waiting for that phone call that something bad had happened but luckily everything went well through no skill or knowledge of mine but just the universe smiling on me that day. That's absolutely not the way to do surgery." [Interview participant 8]

Interview participants also disliked and were impacted by a perceived inconsistency in the level of responsibility given to them (for example between day and night). From time to time there was a perception of a hierarchy for accessing surgical hands-on experience and this was often described as having a negative impact on motivation in addition to being in contrast with their experiences of feeling inadequately supervised. In these circumstances again the concerns relating to the ability to provide excellent and safe surgical care for the patient were apparent to the trainees and worried them.

"I was basically allowed to do admitting through the Emergency Department and consult patients but when it came to time in theatre and asking how much I could be involved with in assisting with operations it was a given that you were at the bottom and there is a lot more people here. It was sort of like we don't have time to teach you, you need to wait until you are a few more years into training and then it will be your turn to learn. Because I wasn't actually doing much operating at all and not being given the chance to display what I had already learnt, I definitely felt I went backwards through not keeping my skill set up." [Interview participant 11]

"For example someone you ring up for advice when you are on-call, you may not necessarily work with the person who you are calling that is the way the system works, and they demand certain operations that wouldn't be expected of someone at your level. There is a surgeon there who is notorious for not coming in to the hospital when he is on-call and its quite contrast during the day during elective procedures he won't let junior registrars touch the patient, even the Fellows do minor things like put on the dressings, they don't do a lot of operating and not what they are there for. At night he's just happy, 'crack on, take that bowel out - you'll be right'" [Interview participant 20]

And finally, supervisors were described in negative terms when they were seen to demonstrate unprofessional behaviours such as physical abuse, shouting and public humiliation of the trainee.

"... you don't want to be humiliated in public and that is what a ward round ultimately is." [Interview participant 17]


"He was a complete an utter joke, totally inappropriate. He was having an affair and asked me to change his Facebook settings so that his wife wouldn't find out. He told me all of this stuff that was totally inappropriate. I know you spend a long time together with somebody but really" [Interview participant 14]

"She was just a destructive force. Any mistake you made you would be screamed at. There was no point where she encouraged your skills to develop. ... It was a horrifying experience to work for her. I saw her reduce a number of registrars and residents to tears. She was pretty much as horrible a person to work for as you could imagine. She just threw tantrums like a two year old. She might as well have got on the ground and thrown her fists around like my two year old. That was her behaviour on a ward round in the morning. It was like working for a two year that just couldn't control their behaviour ... In a very public environment in front of patients, in front of the nursing staff, in front of the residents. She would just start screaming at you and walk off in a huff.." [Interview participant 10]

He is the one who used to throw instruments in theatre, he would hand smack trainees. I hated going to surgery with him not because he was bad because I was thinking when is it going to be my turn, is he going to be in a bad mood or good mood. You start to think why is this, I'm going to surgery to learn not to be worried that it might be a bad day for the surgeon. I hated working in his team.

INTERVIEW PARTICIPANT 13





How effectively is
surgical training
administered and
governed?





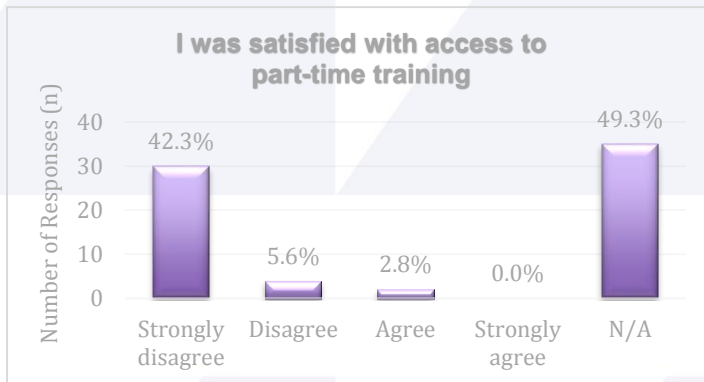
HOW EFFECTIVELY IS SURGICAL TRAINING ORGANISED AND GOVERNED?

SURVEY COMMENTARY

Survey participants were asked for their perception(s) regarding College administration, organization and governance processes.

Approximately 70% of survey respondents agreed that the training requirements were clear. There was a gender difference in the responses to this item. Women were more likely than men to report that they agreed to finding the information on training requirements clear.

Almost 70% of survey participants disagreed that the training programme was flexible to meet their needs for interruptions to training with approximately 50% of respondents 'strongly disagreeing'. With only 30% of survey participants reporting formally interrupting from training, this outcome suggests that participants seeking interruptions were unable to do so or interruption limits were exceeded. Responses to this question do not align with the outcome regarding satisfaction accessing leave so potential terminology issues with this item regarding taking leave during a placement and formally interrupting from training do not appear to hold true.



48% of respondents disagreed that they were satisfied with access to part-time training. 50% of respondents did indicate a non-applicable response to this item. This outcome suggests that a high proportion of survey participants felt that part-time training was not an option for them.

60% of respondents disagreed that they were able to gain suitable training experiences. Based on responses to other items within the survey this can be attributed to not being allocated to placements according to preference and experiences such as bullying in specific placements.

The survey explored perceptions to interactions with RACS staff. Almost 50% of survey participants agreed that RACS staff were supportive when enquiring about training requirements. Approximately 60% of survey participants agreed that RACS staff were helpful, prompt and courteous at all times. Interview

The college is unsupportive, uncompromising and insensitive to its trainees and their needs. The old way to do things is outdated and not appropriate for today's trainees.

SURVEY RESPONDENT 19

Survey participants were asked if they were satisfied with access to leave. Opinion was fairly evenly divided with half of the respondents agreeing and half of the respondents disagreeing on this subject. There were between group differences for those who were undergoing general surgical training and other surgical specialty training. The group in general surgical training were more likely to be in agreement that they were satisfied with their access to leave.

Transparency, equality, empathy from RACS. The people who are on the senior positions at RACS and the teaching hospital are the ones who are the bullies.

SURVEY RESPONDENT 37



participants were asked a series of questions regarding interactions with the College to further clarify the survey responses and to identify suggestions for improvement.

Communication about training requirements was perceived positively by survey participants. 70% of respondents agreed that they received relevant and timely communication regarding training from RACS.

In general respondents were satisfied with the administration of the training programme. Considering that many survey respondents were involved in the transition from basic surgical training to the SET programme as well as significant training and assessment changes this is a positive outcome.

Specific specialty Boards and their associated processes were reported negatively and there appeared to be inequity in the provision of training across the specialties. Clarity on the role of the College, Specialty Boards, supervisors and site/hospital specific responsibilities is needed to assist with addressing trainee expectations.

See *Appendix F: Survey Analysis* for further detail of the analysis of responses to items regarding College administration, organization and governance processes.



INTERVIEW INSIGHTS

Interview participants had a range of thoughtful suggestions about the structural and organisational aspects of training. Many concerns provided were related to aspects of the allocation system. Others related to the actual workload of training – particularly when there were too few trainees in a department to provide adequate relief from on-call responsibilities. Examples of comments relating to workload are provided below.

“Having adequate numbers of trainees at the hospital. ... One recommendation is ensuring that the training sites are adequately staffed to prevent burnout amongst the trainees.” [Interview participant 3]

“I don’t think doctors should be contractually set to 40 hours and no more, I’m quite happy to work 50, 60, 70 or 80 hours a week but its draining to do that 52 or 48 weeks a year. The idea that you have to do 80 hours every week is just unreasonable. I don’t think it needs to drop to 40 but there needs to be a system in place say maybe one out of four you are only doing 40 hours and the other times you do 60 or 70 or 80 but once a month you get to do a 40 hour week and once a month all you do is turn up at 8 o’clock at theatre and operate for the week and you don’t have to worry about other stuff.” [Interview participant 16]

“They probably need to reduce the requirements. ... My first year of training I was constantly exhausted. I had my exams to study for to ensure that I’d get into the second year of training ... It just comes down to that whole concept of just give us your life, we don’t really care if you don’t sleep and don’t ever see your friends or your family, that’s irrelevant.” [Interview participant 18]

There was only two registrars so if you went away for a week the other registrar was on-call for two weeks straight. It was a nightmare so we didn’t take any leave as neither of us felt like we wanted to impose that on the other. ... There has got to be a way ... to have some cross cover from maybe other hospitals or flexibility in the system to maybe have a floating registrar or consultant does a couple of nights on-call or something like that.

INTERVIEW PARTICIPANT 8

Many participants expressed concern about the system of placement allocation. Not only was it viewed as lacking transparency, but it was also poorly understood in terms of the necessity to be moved so often and the inability to plan far enough in advance to provide reasonable notification. Participants conveyed that they felt that improvements could easily be achieved with a willingness to do so at a College level. One participant thought that a ballot system would be easier to accept than the system that they had experienced with seemingly capricious decision making and late changes.

You go through the process of choosing preferences, have them ignored and then be sent wherever the College wants you to go. That’s just ludicrous. No other College does that but ours. I don’t understand why they can’t sort that.

INTERVIEW PARTICIPANT 14

“I think it is good to get variety. I chose a specialist field where you did need to have different inputs but moving once a year every year is just too much.” [Interview participant 7]

“I appreciated when I signed up that every six months I would get moved and that I wouldn’t necessarily get moved with my partner but I was definitely unaware of the fact that once I had signed one of these contracts that I could be moved at a drop of a hat in addition to every six months ... Even though they [trainees on a different

specialist programme] still had to move around as we did, it allowed for more longer term planning in knowing where they would be and being allowed the opportunity to relocate with ample time with children and things like that. I certainly think that would be ideal if something like that system is implemented. People can then know at least for the next four years this is what my life is going to look like and that just makes it easier than being told every six months where you are going. For me that was the biggest thing around inflexibility. ... I know there would be a greater retention if people thought the College is open to sitting down and discussing options and helping them work through that instead of not allowing it or making it so difficult that people just don’t bother trying.” [Interview participant 11]



One of the educational impacts of such regular moves was that some participants felt that they lacked continuity in their assessments which did not appear to them to accurately reflect their abilities.

“It is very unusual to spend two years in the one unit so you get lots of different educational supervisors who are filling in these appraisal forms for you and I wonder if there should be something that you take with you to your next unit to say this is the level that [this trainee] is at, this is how she acts with patients and colleagues, how she operates, her technical skills so they can see what the baseline is. Otherwise they are filling in their forms after six months and filling in blind. I just think that the form the [hospital] people filled in, which was very bad about me, should have been highlighted as it was so different from the other forms that I had and there must have been a reason behind that. Why was I suddenly bad, did I no longer want to do [other surgical -specialty], was I ill, was I getting side tracked with extra-curricular activities, what was it that made me bad rather than just telling me yes I was bad which wasn't very helpful.” [Interview participant 5]

In terms of the training programme structure and requirements, whilst these were generally understood, some participants did make reference to the inconvenience and difficulty caused by regular changes to requirements.

“The biggest thing is they need to stop changing it so often. Since I was interested in becoming a surgeon every single year since 2010 they've changed the selection process, they've changed the interview format, they've changed the CV points, and they've changed everything. It's becoming a joke. They keep moving the goal posts.” [Interview participant 20]

Access to leave was also cited as being an issue in the training programme. Many examples were given of difficulty with parental leave. Some trainees also thought that interruptions to training should be more easily accessible and unquestioned, particularly given the high workloads that trainees had to sustain for long period of training.

“Maybe it would be good for people to know that they can take six or twelve months off without a reason. I had to have a medical reason for taking twelve months off and I don't see how that necessarily should have happened when you are dealing with people who work continuously. ... the only way they can get six months off is if they have medical grounds for it or do a PHD, or become pregnant.” [Interview participant 16]

There were multiple pleas for increased flexibility and for part-time options to training in particular.

“It was very difficult there was no consideration about family or those sorts of things.” [Interview participant 7]

“I had a mini-stroke like episode in my second year of training and there was some flexibility in that whatever doctor I was under signed off on the medical certificate and they couldn't really argue with that but there was very little flexibility from the College and my supervisors who were like “back to work, back to 100%”. I tried to explain that I have had a mini-stroke, it's not exactly like I can go back into full time training 100%. There was no flexibility in that regard. For me that was the icing on the cake and I knew I wasn't going to pursue surgical training anymore. If you have a mini-stroke and still can't get the time off you need, it really is a stupid system.” [Interview participant 10]

I think the assessments I received the processes were fine. I think that you need someone from each unit who is dedicated to the trainees, which I'm sure is happening and happened, who is going to sit down with you every three to six months to point out your deficiencies and where you are doing well. I think that is all you need.

INTERVIEW PARTICIPANT 17

If I had the opportunity to talk to someone from the College in a totally external environment separate from work completely, maybe I would have stuck my hand up and said actually this isn't ok. That networking facility is really helpful and they don't offer anything.

INTERVIEW PARTICIPANT 14

And flexibility extended to looking more creatively at other roles within surgery and at collaborative training with other specialists. In certain circumstances this was perceived to leading to a better outcome for the trainee and less ‘wastage’ in terms of a trainee's surgical capabilities from the time invested in their surgical training. Suggestions included a professional programme or pathway to surgical assisting and collaboration with radiology in terms of neurological procedures.

“... considering how much effort had already been put in for my training, it seems like a waste to say let's just get rid of him and move onto the next trainee. It would have been much better for everyone involved had there been something in place to address issues and allow someone to come back. I've almost completed my radiology training in neuroradiology and plan to do



interventional neuroradiology. For someone like me it would be invaluable to have a few extra years of neurosurgical training so that I would be able to both pick `aneurisms not just coil them as I plan to do. Because of the way the College programme is structured I would never be allowed to get that training". [Interview participant 10]

Participants described educational structures that could be put in place to support training such as having designated tutors to provide regular and consistent feedback. Several descriptions were also provided justifying the need to have an independent system of enquiry in the case of difficulties in training. An ombudsman type model was supported by some as a means to resolve difficulties.

"Having a conflict resolution person at the College who could help you a little bit and functions in a counselling role. ... I think it would be useful to have especially when you've got issues that you can't articulate properly or resolve by yourself." [Interview participant 3]

And in terms of how the College organisation is perceived, opinions were divided. Whilst some negotiated effectively through the system, typically there were perceived problems. Some areas for improvement were indicated and the College administration was typically viewed as 'faceless'. Trainees wanted to be dealt with openly, empathetically and as individuals.

"They said to me ... is there anything that went wrong, that was on the phone. I started to hint that yes there was a problem. This woman, she was admin but high up as a manager or something, she started immediately defending whatever I said. It was clear she was closing the doors. I thought it was a process where she had to ask the question. I said to her 'ok you're right' and just thought why are you wasting your time, you've made the decision, this is the culture and she is going to defend it and is just doing her job to document somewhere in my file that we discussed it with the registrar. I just thought it was very rehearsed and why ask me then?" [Interview participant 13]

"Even that I have heard ... that it is damn near impossible to get an interview with the College. They are not accessible. They weren't considered to be a group that gave a rats about me, they didn't want to actually know me or sit down and talk to me. I got that impression. Maybe there could be a process. With the end of term assessment maybe there could be an option. A lot of people are scared because of the anonymity and I personally was too. If you asked for my feedback on rotations it was always positive, partly because I had good experiences, the one rotation that I didn't have a good experience I still gave positive feedback because you know the consequences aren't worth it. A lot of people don't feel like they can trust the College. That really comes down to the trainees are treated like they are a nothing. You are not valued and are just a number. You give negative feedback and you are then easy to replace." [Interview participant 18]

"The biggest gripe with the whole system is how the College dealt with it. It was just a generic letter reply to me to advise me that I am on leave there was no "is there anything we can do to help?" It felt like they didn't care if I came back or not. ... My opinion of the College at that time was you are happy to take my money and set my requirements but whether I am here or not you don't really care. Your interest is to make surgeons but you don't care about them as long as they meet the requirements that you set out for what a surgeon should be." [Interview participant 16]

"A phone call, an email, just some interest. Someone to ring up and say you want to quit, why, how come, what is going on, tell us all about it. That would be great to have someone ring me up and show some interest. ... The College didn't offer any support and that would be really good." [Interview participant 14]

There were also reported experiences in which interview participants experienced a lack of coordination between different parts of the College.

"... you had to apply for approval to quit the training programme. ... I put in the application to resign and then be approved. I was thinking 'what are you going to do if it's not approved?' It sounds terrible but it summarises the Colleges attitude. The worst part was once I quit and got my approval to quit the programme for at least twelve months afterwards I kept getting letters from the College saying I needed to pay my College fees, this was after I quit. The left handers didn't talk to the right handers and was just an admin issue but no matter how many times I rang them and said I have left, I'm not paying you anymore College fees, I am no longer a member of your College. The people I got at the other end said that they still had me listed as a trainee. ... That went on for twelve months. They became very nasty. They would send me letters saying they were going to kick me off the training programme unless you pay your fees and they were really quite mean. It was really frustrating. For an organisation that was so meticulous when dealing with my errors, it's an insult that you are then sending threatening and insulting letters because it's your error. It was just the nail in the coffin." [Interview participant 18]



Examples were provided where trainees who were quite clearly suffering significant distress were not treated in an understanding and empathetic manner.

“... I had indicated in that letter that part of the reason why I was leaving training was due to marital stress. I then received a couple of emails requesting that they wanted to know more detail and I felt that was very intrusive ... That was accepted eventually but I had received a few emails from an administrator asking for more detail and I felt that was very intrusive and perhaps I would have been more willing to discuss these things if I had been given a phone call. Asking for these things over email ... It was ... an administrator ... requesting further detail after I had already indicated that I was leaving training due to marital stress. I said I did not feel that they needed to know any more detail than that particularly in the manner that I was asked.” [Interview participant 21]

And finally, in terms of administering the departure from training, there is an opportunity for the College to make the process more humane and personable even when there have been difficulties with the trainee.

“There was no option to give any feedback. This survey and interview is the first opportunity.” [Interview participant 5]

“I cancelled my gym membership at the end of last year and that was harder to do, they asked more questions. Just that simple why are you leaving, is there some reason why you are leaving for that we can fix or change?” [Interview participant 16]

“The College of Surgeons really made you feel like they dictate your life to you and your training centre when it suits us but when it gets tough you are on your own. That was the perception I got. They then stuck the knife in a little bit more by saying by the way you have to apply to leave, we aren't just going to let you. Not at any point did they ever say is there anything that we can do to help, is the reason you are leaving due to training requirements and is there anything we can do to help. I think they have just got to accept that this is a new world. ... they need to be a lot more flexible. They need to treat each trainee as an individual not just a number. Yes there are training requirements but we are individual people. [Interview participant 18]

The trainee could provide some feedback about their experiences or what they found was particularly helpful. Having said that it might be difficult when they are trying to get reliance on a reference. I'm not sure how honest you could be about the training you receive in that unit. It would have to be later and done from the College rather than the unit they were working in just to provide feedback about what was good or bad about a unit.

INTERVIEW PARTICIPANT 18

In terms of feedback, a couple of small group of participants expressed concern about ongoing impact on their professional careers and fear of the College jeopardising their chances of progression in other areas of medicine. This was seen as a potential barrier for giving honest feedback to the College on their experiences within training.

The vast majority of interview participants stated that they had found this study with the survey and telephone interview to be helpful to them and perceived it as being professionally and objectively conducted and addressing pertinent questions.

“An independent interview plus or minus a survey would be good. Something very similar to what you are doing at the moment. I think you would probably want to do it one to two months down the track. I think you don't want to do it on the day they quit because there is going to be a lot of raw emotion in there. ... Like I said probably in the situation with having a grace period so that they can give feedback, the College can address whatever issue there is and it might be possible for that trainee to come back and resume training at a different centre.” [Interview participant 10]

And participants were quick to suggest improvements for egalitarian reasons rather than for personal gain.

“I am worried about exactly what you are worried about which is retaining high quality candidates. I am happy to go through this in detail. My advice would be make sure things are in place so that they feel safe and supported and then once the dust settles then you should approach them to say let's talk about what could be done better. If the tide is turning and the College is getting it right I don't think you need to do it forever, you don't need to continually self-audit. I think you need to do periodic and targeted self-audits but I don't think you need to do global assessments of why people leave because eventually you will start getting a sense of it. I suspect this process will give you a lot of information. I think you need to have a focussed, time sensitive process in place. I would give them twelve months to get your life in place and get things in order and then say ok can we have an hour of your time, we want to know what's going on. ... That would be what I would do if I was in charge” [Interview participant 17]





Final messages for
RACS





FINAL MESSAGES FOR RACS

LONG TERM IMPACT OF TRAINING

Interview participants were asked to conclude their interview by providing their final messages to RACS. This section of the interview attracted a variety of responses from broad commentary related to the work the College is doing currently to improve the surgical culture to comments on their own personal circumstances and learning points from their experience of training.

In terms of resolution, participants were very positive about what they had learned during surgical training with many of them commenting favourably on the skills and abilities that they were able to use after withdrawal. These related not only to surgical technique but also to learning to work effectively with surgeons and also gaining resilience.

Typically the participants had 'made good' of their experience even when it had been difficult for them. The majority had gone on to progress efficiently through other specialty training programmes.

"It prepared me for procedures and prepared me for difficult work environments and work hours." [Interview participant 3]

"It did give me a lot of really good skills. One of them is around making quick decisions." [Interview participant 8]

"It's left me with some really important skills that I'm really glad I have. It also taught me a bit of resilience which you need in ICU as well." [Interview participant 17]

And there were a number of comments that related to learning from adversity and making conscious choices to reject negative role models.

"It certainly gave me a thicker skin and helped me get a few skills for life in general about dealing with different personality types and negativity and how to engage in those situations." [Interview participant 11]

"Surgery has been helpful so I don't see it as being a waste of time, it's been very useful in some respects. From a management and administrative perspective, surgical training made me see what ways are not the best way to handle things. The training made me work out how could I improve and how could I do things better so that has been helpful." [Interview participant 12]

Several participants mentioned a loss of confidence or trust that either took a long time to resolve or was providing ongoing challenges.

"I do get very anxious about dotting the I's and crossing the T's because I still haven't accepted my new College. I am two years in and into my third year and I haven't accepted that these guys are chilled out and are as easy to deal with as they are. I am still waiting for them to turn around and say by the way x, y and z. They treat me like an adult." [Interview participant 18]

"I think it made me a harder person. I had a lot of positive experiences before getting onto surgical training in terms of good supervisors and being encouraged. I think surgical training taught me to be very hard, to not rely on other people and to not really trust supervisors. I never put any faith in supervisors and never trusted them after that. In [my new specialty] I just became extremely independent and never relied on anyone. I don't think that is always a good thing but that is the result of my surgical training. I guess I've got a much thicker skin after that." [Interview participant 10]

"The negative impact is it did take me a lot of time to rebuild my confidence. I did come from a strong culture of condescending and bullying. It took me a long time to actually think that wasn't right. When I went to [my new specialty] I was very scared of the supervisors. One supervisor told me 'Why are you so scared?' I was like 'Ok I can contribute, I can be part of the team' It did take some time." [Interview participant 13]

The positive aspect is that it has made me a much better doctor as I now prioritise very well, I know what is urgent and what's not urgent, I don't get stressed when the waiting room is full of people because I've dealt with things under pressure, ... it made me a tougher person and tougher clinician. Decision making I think I'm really good at it and recognising unwell patients from just first instant.

INTERVIEW PARTICIPANT 13



For a small group there was a long term personal cost involved with their time in surgical training.

“The issue for me throughout surgical training was I put off having children because I wanted to be a surgeon. By the time I quit I was too old so never managed to have children.” [Interview participant 7]

And for some, an unresolved feeling of regret that they had not been able to achieve their ambition of a career in surgery.

“Most trainees still manage to learn and still manage to pass the term and become good surgeons. I was not one of those trainees and with a better learning environment I could have become a surgeon but I didn’t have the energy left in me to find that better environment for myself to stick at it.” [Interview participant 2]

“Just utterly disappointed. At the time I was heartbroken and now I’m just disappointed.” [Interview participant 14]

And some unresolved confusion about the ongoing nature of training issues that were perceived to be resolvable.

“I don’t know why someone has to move every six months. If you surveyed every surgeon and said how long would it take you to get to know a registrar well in terms of their clinical capabilities and operating ability, six months would be about right and that’s when they are being shipped on. You are getting people who are just warming up to people and then they’ve got to leave rightly or wrongly so maybe they should stretch out the six months, why six months, has anyone asked the question.” [Interview participant 20]

In terms of advice to RACS, the participants had many positive suggestions about what could be done to enhance the experience of surgical training including means to enhance retention in training via educational good practice. Some conflicting views were also expressed about the direction of change and reform.

What the College is doing is excellent. ... Excellent for the College of Surgeons taking a lead on this issue. It is addressing what has for a long time been accepted as the norm. It is fantastic and think it will have a long term impact if we continue with the efforts.

INTERVIEW PARTICIPANT 22

“I think that there needs to be the development of a far more caring approach to training. I don’t think supervisors should be supervising trainees if they aren’t committed to teaching and supporting them. The other thing I think is that if there was a sentinel event that occurred in a trainee’s training then there needs to be some facility for the College to acknowledge that and address it with the trainee.” [Interview participant 7]

And others provided more global direction on the broader issues that the College is addressing at the moment. We will draw this report to a close with a collection of their considered advice and final messages.

“The surgical training needs to start from day one to incorporate a better respectful culture. It needs to start from the beginning because unfortunately there are lots of trainees now, because they want to be like their bosses, behaving like them. I think we are forming more and more of those bad people.” [Interview participant 13]

“Overall the training programme is good and its fun and you get a great variety of work. I think a little more focus on advocacy and work-life balance and a lot more focus on people that are struggling and taking time off would be good for the college. I think communication between them and their trainees and some sort of formal set up where they can support trainees when there is a problem.” [Interview participant 16]

“Something needs to change otherwise they will see more and more people who are contemplating their career choices. As part of an online forum group for medical mothers the discussion about work-life balance, training requirements and changing career direction comes up multiple times every single day in this group across Australia and New Zealand. It has several thousand women in it and certainly there are a lot of people contemplating leaving training. If something doesn’t change and it’s not made more flexible they will lose more trainees as time goes on and other career opportunities become more and more attractive.” [Interview participant 11]



Several calls for a contemporary and trainee focussed approach to training were made. And additionally a call for increased internal respect and collaboration.

"I honestly think that they are just looking at modern society the wrong way. I think they are giving the perception, whether they do or don't intend, that surgeons are better than other doctors and that they think they are better than everyone else and are treating their trainees like they are worthless. It is almost like if you are treated like you are worthless for five years you become better than everyone else. Whether they do or don't push that it's a whole misperception. ... I think they would get a lot more support from other disciplines in medicine if they were a bit more cohesive as a group and a bit more cohesive with everyone. We will go to meetings with respiratory physicians and we are all friends and all get along and they respect our job and we respect theirs. We go to meetings with surgeons and they really do give the impression that they don't respect you one iota. ... They don't get a lot of support from each other and don't get a lot of support from anybody else because of that. ... A perfect example is when you go to the morbidity and mortality meetings as a surgical reg you watch bosses tear other surgeons apart. I said the comment the other day that when you are a surgeon you don't know who is your friend and who is your enemy. They aren't a cohesive group at all." [Interview participant 1]

"The only thing would be if they are serious about cutting out bullying and harassment they need to show people that they are by demonstrating it by not putting bullies into more positions of power as that is the sort of thing which I've seen. I think they are rewarding them for poor behaviour to be honest." [Interview participant 21]

"My final message is get everyone trained with some educational principles because there are some basic things that even a short training course could help supervisors know about so that they don't fly by the seat of their pants and they are aware that the learning process is a very real phenomenon and requires some very key ingredients to get right so that the learning process is seamless and painless for the learner." [Interview participant 2]

And a final word from two participants who both felt strongly that there was much to learn from the group who had left training for whom this study has provided a voice and a means to express their view and be heard.

"I think they need to look at the people in their committees and groups and all the people on the boards. It is tricky as the people that look into it are their own people so it's a lack of insight into their deficits. They need to listen to people that have left and look at the reasons why. ... I think they really need to change the way they do things because it is going to impact on clinical care and patients in the future when you continue to have people in that toxic environment. There are people that can get through the surgical training programme and learn those types of behaviours and subsequently the same type of surgeon is produced. That's probably the message that I would give the College of Surgeons." [Interview participant 12]

"I think it's fantastic that they are interviewing trainees, it's wonderful. Thank you ..." [Interview participant 3]



Summary of Recommendations





SUMMARY OF RECOMMENDATIONS

I. THE OVERALL TRAINING EXPERIENCE WHILST IN SURGICAL TRAINING

Training experiences are inconsistent and do not always adhere to educational best-practice. Whilst training can appear to be clinical service rather than educationally focused it does not always fulfil either goal.

- Consistency with training experiences in general and other surgical specialty training needs to be assured.
- The culture of surgical training must be enhanced with particular regard to discrimination, bullying and sexual harassment where zero tolerance should apply.
- Surgical culture is not consistent and improvements should be made by researching and promulgating best practice. Some fruitful lines of enquiry include:
 - Positive learning experiences at undergraduate and junior doctor level
 - Positive learning experiences in rural surgical placements
- Implement routine, independent programme evaluation that enables trainees to confidentially report on any local training issues that need to be tracked and followed-up separately to their individual experience. Systems need to be in place at a College level to coordinate this activity.

II. THE EXPERIENCE OF ASSESSMENT WHILST IN SURGICAL TRAINING

Whilst assessment was not viewed entirely negatively, there are some changes to be made that could have a major positive influence on all trainees including those who are considering whether to leave.

- Track trainees carefully through the training programme. In particular, take note of any changes in performance that may indicate that they are struggling and pay particular attention to the transition at the beginning of training.
- Make ongoing efforts to ensure formal assessments are an authentic reflection of the knowledge, skills and attributes required for specialist surgical practice. Check that systems are optimised to do so and assessors are trained.
- Centralised quality assurance mechanisms to coordinate assessment processes across all surgical specialties.
- Research differences that are perceived between formal assessment results and informal verbal feedback provided. It is likely that training in the provision of timely, accurate and professionally appropriate feedback will be required.
- Provision of constructive and corrective feedback on trainee performance in the workplace needs to be a training programme priority promoted at all levels of the training programme.



III. CLINICAL SUPERVISION AND MENTORING

Significant examples of unprofessional conduct from mentors and supervisors are reported in this study. Such experiences had a significant negative impact on a substantial group of trainees who withdrew from training.

- Confidential reporting or whistle-blowing systems may assist with early identification of problematic areas. A zero-tolerance culture should be promoted.
- Longitudinal and intense mentoring for a targeted group of trainees at risk of withdrawing from training may be of benefit. The system will need to be in place for this to occur and mentors will need to be carefully selected, trained and supported.
- Commitment of resource to supervisor training and establishing supervisor support networks across all surgical specialties to promote best practice including speaking out against unprofessional educational practices.
- Feedback remains a focus and all clinicians with contact with trainees in the clinical environment need to be well-versed in the appropriate process and content of constructive feedback.

IV. TRAINING PROGRAMME ADMINISTRATION, ORGANISATION AND GOVERNANCE

Systems and structures are currently viewed as unnecessarily inflexible and unreasonable in terms of impact on life circumstances.

- Recruitment to training: Provide a realistic portrayal of surgery as a career at all levels from medical school to training selection and beyond.
- Recruitment to training: Work collaboratively with other 'technically orientated' medical disciplines (e.g. diagnostic radiology and cardiology) to demonstrate the variety of possibilities that exist outside of surgery to have rewarding medical careers.
- Increased transparency around the training programme is required – what it is really like and what are the genuine expectations. Consider mechanisms to communicate the detail and reality of a life in surgery.
- Training in assessing applications and requests for allocations as well as making placement decisions. Training experiences need to be made equal for all trainees and take into consideration reasonable life circumstances. This will address the perception that placement decisions rely on the College's ability to select and allocate experiences and placements on some subtle nuances of differences in clinical experience.
- The placement system and mechanisms should be reviewed with a view to radical reform. In particular, with reference to part-time and flexible training options.
- Making regular and significant changes to training can have negative consequences particularly with stakeholder buy-in and uptake. The College should allow time for initiatives to be properly trialled, pilot test new ones and give appropriate lead in times and transition arrangements for changes – especially changes to assessments which can otherwise be viewed as capricious.
- Offer an articulated pathway for those who cannot complete the specialist surgical training programme such as a non-specialist training pathway that qualifies practitioners for a career as a surgical assistant.
- Governance coordinated centrally for Specialty Board processes. There are some inconsistencies with how training is delivered that need addressing.
- Increased central coordination/input into training, assessment and remediation requirements to improve standardisation across the surgical specialties.
- Improved transparency with College processes: selection, assessment, appointment to committees and leadership roles.




V. THE EXPERIENCE OF LEAVING THE TRAINING PROGRAMME IF REQUIRED AND APPROPRIATE

The withdrawal process is not currently handled optimally at the College.

- RACS needs to engage more closely during the time of withdrawal to provide an improved experience for trainees who have to leave the training programme.
- Resources should be committed to supporting trainees in difficulty who may be at risk of withdrawing unnecessarily.
- Talk to those that are leaving – give them a named contact on the College staff (e.g. a staff trainee advocate role) and a named clinician ‘case-manager’.
- Trainees are frequently leaving surgical training with unresolved issues. The College should provide opportunities for early and unbiased exploration of the issues involved as in an independent ombudsman model.
- Provide a uniform, consistent and coordinated leaving experience irrespective of general or other surgical specialty training.
- RACS should engage in dialogue with other Colleges regarding trainees who pursue a second training pathway having left surgery.
- Many trainees who withdraw have had confusing experiences and inconsistent feedback. They have often experienced a disconnect between the feedback they get formally, informally and over time. This disjuncture needs to be fully understood and systems providing honest feedback established.





Appendices A – G:

- Study documents
- Study instruments
- Study demographics
- Survey analysis





Appendix A: RACS Study Introductory Letter





A: RACS STUDY INTRODUCTORY LETTER

Copy of email sent by RACS on Thursday 08 October 2015

Dear Dr X,

As a previous surgical trainee, I am writing to you regarding a study to inform enhancements to the Surgical Education Training (SET) Program overall.

The Royal Australasian College of Surgeons (RACS) introduced the SET Program from 2006 and it was fully underway, with all the associated changes, by 2008. In the second-half of 2014, an evaluation of the SET program was conducted within the College, establishing that attrition from the program was considerable (around 13%). This evaluation also identified that women were more likely to leave the program than men (odds ratio 2 – 2.5) depending on the parameter. The next step in the evaluation process is to further explore the reasons for trainee withdrawal from SET

As you may be aware, the College has been under extensive review by the External Advisory Group since March 2015. The EAG 'Report to RACS' has now been published. Not surprisingly, the EAG, being aware of the attrition, has also strongly advised the College to undertake this important area of work.

All previous trainees who formally withdrew from the SET Program between 2008 and 2015 are being invited to participate in this study. On behalf of RACS, I encourage you to participate in the study being conducted by the Ardnell Group to identify factors that raise the risk of leaving training and help develop practical strategies to improve retention of trainees. Participation in the study includes completion of an online survey relating to your withdrawal and training experiences. You will also be asked whether you would be willing to be contacted by The Ardnell Group to participate in a follow-up interview. The people involved are well qualified to do the study – they are not College employees and the surveys, possible interviews and analysis provided to the College as part of the report will not include any identifying information.

Further details on the study will be circulated to you directly by The Ardnell Group in due course.

Should you wish to access any support or counselling services, then the Concierge system would be extended (as if one was still a trainee). Should you wish to contact me directly, my email address is provided.

Yours faithfully

Stephen Tobin
Dean of Education





Appendix B:

Ardnell Group Study Invitation





B: ARDNELL GROUP STUDY INVITATION

Copy of letter sent via post by the Ardnell Group Monday 19 October 2015



Re: Withdrawal from Surgical Training Study

We would like to invite you to participate in a study which explores the reasons that trainees withdraw from surgical training.

Why are you being invited?

You have been identified to participate in this study as a previous surgical trainee who withdrew from the Surgical Education Training (SET) Program between 2008 and 2015. Participation is entirely voluntary.

Who is conducting the study and how will my information be used?

This study has been commissioned by the Royal Australasian College of Surgeons (RACS) to be conducted independently by an educational research consultancy (The Ardnell Group). This study has received ethics approval in accordance with the NHMRC Human Research Ethics Guidelines. This Ethics Application 35 was approved by the RACS Ethics Committee (EC00287). If you have any questions or concerns about this project, please contact the Ethics Committee Secretariat on (03) 9276 7446 or via email at ethics@surgeons.org. Any information you provide will be used to identify factors that contribute to decisions to leave training. This will inform the development of practical strategies to improve the experience of training for surgical trainees in the future. These will be developed with a view to enhancing retention.

Will my information be identifiable?

All your responses will be confidential and de-identified prior to the data being provided to RACS in summary format. **The only exception to this would be if you provided information that was reportable to meet Australian and New Zealand government, legal or authority requirements.**

What is involved?

Your participation will include the completion of a survey relating to your training experiences. The survey will take approximately 20 minutes to complete and is in two parts (Part A relating to withdrawal and Part B relating to training overall). You will also be asked whether you would be willing to be contacted by The Ardnell Group to participate in a follow-up interview.

The survey is available online at: <https://www.surveymonkey.com/r/trainingwithdrawal>

If you prefer to participate in an interview only please send an email to hello@ardnellgroup.com and you will be contacted directly to make arrangements to participate. This survey will be open for completion from Wednesday 14 October to Wednesday 25 November 2015.

Results: The results of this study will be reported to RACS to inform enhancements to the training programme and may also be submitted for publication to academic journals.

Contact information: If you require further information, wish to withdraw your participation, have been sent this study invitation in error, or if you have any queries about any aspect of this study please contact The Ardnell Group: Mary Lawson (E: mary@ardnellgroup.com) or Claire Spooner (E: claire@ardnellgroup.com)

Support: If you feel any psychological distress as a result of participation in this project please contact support services including:

RACS counselling support provided by Converge International. Details are available at www.surgeons.org

Lifeline: 13 11 14 or <https://www.lifeline.org.au/Get-Help/Online-Services/crisis-chat> or Beyond Blue: 1300 22 46 36 or <http://www.beyondblue.org.au/get-support/get-immediate-support>

Thank you for your time and for being willing to contribute to the positive development of the SET Program.

Mary Lawson and Claire Spooner
The Ardnell Group





Appendix C

Ardnell Group Survey Instrument





C: ARDNELL GROUP SURVEY INSTRUMENT

This following survey instrument was administered in online format via the SurveyMonkey® platform.

BACKGROUND

All RACS trainees who withdrew from the Surgical Education Training Program between 2008 and 2015 are invited to respond to this survey. The data will assist with improvements to training overall including College processes.

The survey is being conducted by an independent educational research consultancy (The Ardnell Group). Any identifying information is requested for clarification/follow-up purposes only. To protect your anonymity, any identifying information supplied will be removed prior to the data being made available to RACS.

The survey is in two parts. Part A explores the reasons for your withdrawal from training. Part B relates to your training experience when you were a surgical trainee. The survey will take approximately 20 minutes to complete. Please start now by clicking on the 'next' button below.

FOLLOW-UP INFORMATION

The information collected in this section will be treated confidentially by an independent educational research consultancy (The Ardnell Group).

1. Would you be interested in being contacted to participate in an interview to discuss your responses:

Please note that interviews could be conducted face-to-face, via telephone or Skype.

CONTACT INFORMATION

All personal information collected is for clarification/follow-up purposes only and will be excluded from data analysis and reporting.

2. Email:

3. Name:

4. Contact Phone Number:

5. Address:



PART A: REASON(S) FOR WITHDRAWAL

Please complete the following section to provide information about your reason(s) for withdrawal.

6. Please describe in your own words the main reason(s) and circumstances that led to your withdrawal from the Surgical Education Training Program:

7. Please indicate the extent to which you agree or disagree with each of the following factors contributing to your withdrawal from training:

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
I wanted to change specialist pathways (e.g., surgery to anaesthetics)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I wanted to change to a non-specialist medical career	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I wanted to change to another surgical career (e.g. general to orthopaedics)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I wanted to change to a non-medical career	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I lacked technical competence in surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I withdrew to maximise my chances of completing training at a later date	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I withdrew to avoid formal dismissal proceedings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had financial considerations/constraints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had family/carer commitments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I experienced health issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt I was burnt out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was unable to gain suitable training experiences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had unsuccessful exam outcome(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was expecting unsuccessful exam outcome(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had unsuccessful training/clinical assessment outcome(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was expecting unsuccessful training/clinical assessment outcome(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I experienced bullying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I experienced discrimination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I experienced sexual harassment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I experienced adverse patient outcome(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



8. Thinking about when you withdrew from training, please indicate the extent to which you agree or disagree with each of the following statements:

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
I found that interactions I had with my RACS supervisors around my withdrawal to be positive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I initiated the withdrawal process	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was asked to consider withdrawal from the training programme by a supervisor/colleague	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was asked to consider withdrawal from the training program by the Specialty Board	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt supported to make the right decision regarding my training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RACS managed my withdrawal sensitively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. What, if anything, could have been done to prevent you withdrawing from training:

10. Please provide any further comments regarding your withdrawal from the Surgical Education Training Program:



PART B: OVERALL TRAINING PROGRAM EXPERIENCE

Please complete the following section to provide information regarding your experience of the Surgical Education Training Program.

11. Please indicate the extent to which you agree or disagree with each of the following statements:

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
I was satisfied with the training program overall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found the information on training requirements was clear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was satisfied with the overall workload for training (including all assessment and placement requirements)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found the training program sufficiently flexible to meet my needs for interruptions to training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was satisfied with my experience with the Generic Surgical Science Exam (GSSE)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was satisfied with my experience with Specialty specific Surgical Science Exams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was satisfied with my experience with the Clinical Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was satisfied with my experience with the Fellowship Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Prior to withdrawal, please indicate the number of attempts and outcome at the following examinations you made:

	Number of attempts	Final outcome
Generic Surgical Sciences Exam (GSSE)	<input type="text"/>	<input type="text"/>
Specialty Specific Exam (SSE)	<input type="text"/>	<input type="text"/>
Clinical Exam	<input type="text"/>	<input type="text"/>
Fellowship Exam	<input type="text"/>	<input type="text"/>



GENERAL PLACEMENT EXPERIENCE

Please complete the following section to provide information regarding your training placements during the Surgical Education Training Program.

13. Please indicate the extent to which you agree or disagree with each of the following statements:

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
I found that clinical and training activities were well balanced	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was satisfied with my access to leave	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was satisfied with my access to part time training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found that my clinical workload was manageable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found that the level of responsibility I was given was appropriate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found the amount of on-call was appropriate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CLINICAL SUPERVISION & MENTORING

Please complete the following section to provide information on clinical supervision and mentoring availability for the Surgical Education Training Program.

14. Please indicate the extent to which you agree or disagree with each of the following statements:

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
I was satisfied with the amount of clinical supervision/support provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt supported by my supervisor(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found my supervisor(s) to be professional	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found the feedback I received from supervisor(s) helpful to plan my learning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received timely feedback from supervisor(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received appropriate feedback from colleagues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was satisfied with the mentoring I received	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



COLLEGE ADMINISTRATION & SUPPORT

Please complete the following section to provide information on College administration and support.

15. Please indicate the extent to which you agree or disagree with each of the following statements:

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
I found RACS staff to be supportive when enquiring about training requirements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found RACS staff to be helpful, prompt and courteous at all times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received relevant and timely communication regarding training from RACS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. Please outline the most positive aspect(s) of your training experience:

17. Please outline what could have been done to improve your training experience:

18. Please provide any further comments or recommendations you have to improve the Surgical Education Training Program:



DEMOGRAPHIC INFORMATION

Please complete the following section to provide contextual information for your survey responses. Survey responses are strictly confidential and data will be reported in aggregate only (no identifying information will be reported).

19. Gender:

20. Age:

21. Are you an Australian or New Zealand citizen

Australian

New Zealand

22. Ethnicity

23. Primary medical degree:

University

Country

Year conferred

24. Other Degree:

Degree

University

Year conferred

25. Any other qualifications (please specify):



26. Did you complete the International Medical Graduate Pathway prior to entry into the Surgical and Education Training Program:

27. When did you commence and withdraw from training:

Year training commenced:

Year withdrew from training:

28. What was your primary surgical specialty:

29. Did you formally interrupt from training at any time:

30. Total length of interruption period months (if applicable):

31. SET level at time of withdrawal:

32. Location at time of withdrawal

	Region	Area
Region and area	<input type="text"/>	<input type="text"/>
Other (please specify)		
<input type="text"/>		

33. Please outline what you have done since withdrawing from training:

By submitting this information you agree for the above responses to be used for data analysis and reporting regarding trainee attrition and trainee experiences during the Surgical and Education Training Program.



THANK YOU

Thank you for completing this survey. Your responses will be used to identify factors that contribute to decisions to leave training. This will inform the development of practical strategies to improve the experience of training for surgical trainees thus enhancing retention.

Note: This survey has received ethics approval in accordance with the NHMRC Human Research Ethics Guidelines. This Ethics Application 35 was approved by the RACS Ethics Committee (EC00287). If you have any questions or concerns about this project, please contact the Ethics Committee Secretariat on (03) 9276 7446 or via email at Ethics@surgeons.org.

If you require further information about any aspect of study you can also contact The Ardnell Group directly: Mary Lawson (E: mary@ardnellgroup.com) or Claire Spooner (E: claire@ardnellgroup.com).

If you feel any psychological distress as a result of participation in this project please contact support services including:

- RACS counselling support provided by Converge International. Details are available at www.surgeons.org
- Lifeline: 13 11 14 or <https://www.lifeline.org.au/Get-Help/Online-Services/crisis-chat>
- Beyond Blue: 1300 22 46 36 or <http://www.beyondblue.org.au/get-support/get-immediate-support>.





Appendix D

Ardnell Group Interview Pro-forma





D: ARDNELL GROUP INTERVIEW PRO-FORMA

WELCOME & INTRODUCTION

Thank you for offering to participate in this interview. The interviews are the second part of a study exploring the reasons that trainees withdraw from surgical training.

- [If completed the survey] The first part was the online survey which you completed. This interview gives us the chance to review and expand on your survey responses. We are sorry if this appears repetitive. We want to explore your experiences and thoughts in more detail.

OR

- [If did not complete the survey and only agreed to interview]: The first part was the online survey. This interview provides an opportunity to explore your thoughts and experiences in detail.

The information you provide will be used to develop practical strategies to improve the experience of surgical training in the future. This study has been commissioned by the Royal Australasian College of Surgeons (RACS) to be conducted independently by an educational research consultancy - The Ardnell Group that works across Australia and New Zealand. The consultants are familiar with the context of medical education and have extensive experience in all aspects of postgraduate and undergraduate medical education.

All of your responses will be kept confidential and any data provided to RACS will be de-identified and presented in summary format.

INTERVIEW PROCESS

The interview consists of 4 parts as follows:

- Part A: The factors leading up to your withdrawal from training and the impact these had on you
- Part B: Your views on how surgical training should be changed to enhance retention
- Part C: Your views on how the experience of leaving surgical training could be improved
- Part D: We will conclude the interview by offering you an opportunity to provide any final messages to RACS.

Please be aware that you are free to stop the interview at any stage. All interview questions are optional and you can decline to answer any question at any time. The discussion will be recorded for analysis purposes. A transcript summary will be provided to you via email for validation and approval following the interview.

SUPPORT FOR YOU

If you feel any psychological distress as a result of participation in this study, we encourage you to contact support services. We will provide the details for these services immediately following the interview.

ETHICS APPROVAL AND CONSENT

This project has been approved by the RACS ethics committee in accordance with the NHMRC Human Research Ethics Guidelines (Reference: EC00287).



It is a requirement that we have your formal consent to participate in this interview and we have received your completed interview consent form.

CLARIFICATION OF ANY POINTS

Before we start, do you have questions or points that you'd like to clarify about any aspect of the interview?

INTERVIEW START

Please confirm that you withdrew from the Surgical Education and Training Programme between 2008 and 2015 [yes/no]

PART A: YOUR EXPERIENCE

Focussing on your personal experience of the training programme

Please could you start by describing your initial motivation for joining the surgical education training programme?

We would now like to focus on the experience leading up to your withdrawal from training.

- [If completed during survey] Thank you for describing the reasons for leaving the training programme in your survey responses.

OR

- [If not completed during survey]: Please describe in your own words the main reason (or reasons) and circumstances that led to your withdrawal from the Surgical Education Training Programme.

We appreciate you sharing your experience and would like to explore some aspects of that in more detail now.

- Please could you describe a specific example of what you experienced? Either one that is typical / characteristic of your general experiences or one that was highly influential on your decision to leave training?
- What impact did this experience have on you at the time?
- To what extent was your decision to leave training the result of a single incident or cumulating experience over time?



PART B: ENHANCING RETENTION

Your views on how surgical training should be changed to enhance retention

We'd like to start this part of the interview by asking you to compare some of your specific experiences in different surgical units.

- Please can you describe a surgical unit when the training worked well for you? What were the characteristics of that training experience that contributed to a positive training experience for you?
- Now can you describe a surgical unit where the training did not work well for you? What were the characteristics of that training experience that contributed to it providing a negative training experience for you?

Similarly, we'd like to explore what specific aspects of supervision were effective or ineffective for you.

- Can you describe a supervisor who provided positive supervision with whom you feel your abilities in surgery improved?
- Can you describe an ineffective supervisor who provided supervision where you were unable to advance your abilities in surgery?

And we'd appreciate your views and comments on the overall training programme structure and system of training including flexibility and access to leave

- Did you experience any particular structural aspects of training that either helped or hindered progress through the surgical training programme?
- What (if anything) would you recommend to improve training overall in terms of structure and processes?
- Would you recommend any changes to the assessment within surgical training and, if so, what would they be?



PART C: IMPROVING DEPARTURE FROM TRAINING

Your views on how the experience of leaving surgical training could be changed

Several of the survey questions asked you to comment on the actual experience of leaving the training programme. We would like to explore this from the perspective of making improvements for the future.

- What advice would you give to a supervisor if a trainee approaches them and says they are thinking about leaving training?
- What advice would you give to staff at the College for dealing with trainees when they leave training?
- What advice would you give to the College about how you should be treated on leaving the training programme?
- What support would you recommend the College make available to assist a trainee during the withdrawal process?
- When you left the training programme what opportunity was given for you to provide feedback on your experience?
- What should be done to collect feedback when a trainee leaves the training programme? What format should this take? When should it be collected?
- What single factor would have improved your experience of leaving the surgical training programme?

PART D: CONCLUDING MESSAGES TO RACS

Any concluding comments on surgical training from your current perspective

- Looking back now, can you describe the overall impact of your surgical training experience on you in the longer term?
- Please could we confirm what are you doing now?
- Do you have any further comments on training or suggestions for improvements that you don't feel you have had the opportunity to discuss already?
- Do you have a final message to send to RACS?



INTERVIEW CONCLUSION & NEXT STEPS

Thank you for completing this interview. Shortly you will receive a transcript summary of your interview via email for you to validate.

Can I confirm that your email address is: *[insert email address]*?

Please can I ask that you review and return your interview transcript to us within 5 days of receipt?

Findings from the survey and interviews will be reported to RACS in early 2016.

If you feel any psychological distress as a result of participation in this project support services are available:

- RACS counselling support provided by Converge International. Details are available at <http://www.surgeons.org/member-services/college-resources/racs-support-program/>
 - Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand
 - Email eap@convergeintl.com.au
 - Identify yourself as a previous RACS Trainee
 - Appointments are available from 8:30am to 6:00pm Mon-Fri (excluding public holiday)
 - 24/7 Emergency telephone counselling is available
- Lifeline: 13 11 14 or <https://www.lifeline.org.au/Get-Help/Online-Services/crisis-chat>
- Beyond Blue: 1300 22 46 36 or <http://www.beyondblue.org.au/get-support/get-immediate-support>.

We will email these details to you immediately after the interview ends.

Once again thank you for your willingness to contribute to this study. If you have any further comments after the interview concludes please do not hesitate to get in contact again using the contact details we will send you now.

Name of interviewer	
Name of Participant	
Date of Interview	
Start time of interview	
End time of interview	





Appendix E

Survey Respondent Demographics

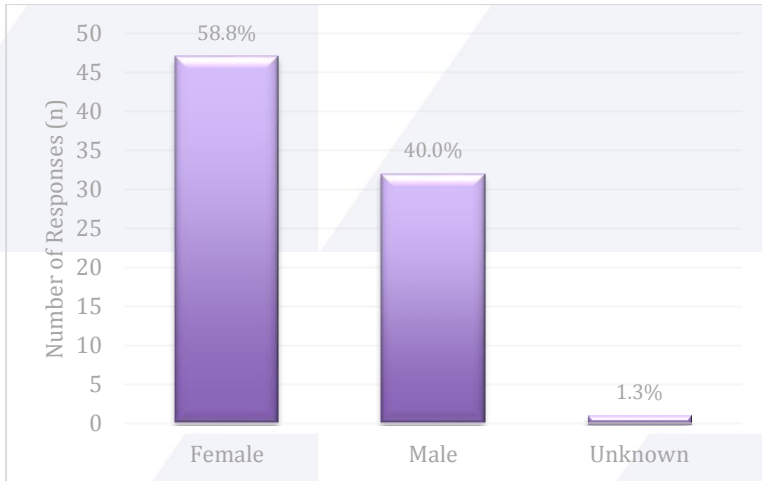




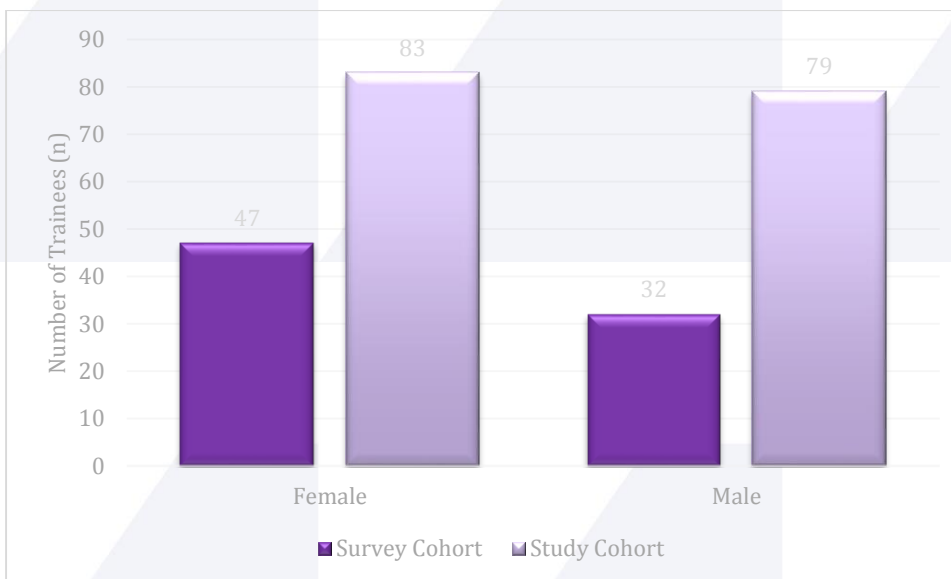
E: SURVEY RESPONDENT DEMOGRAPHICS

This section contains demographic details for the eighty trainees that completed the survey.

Gender

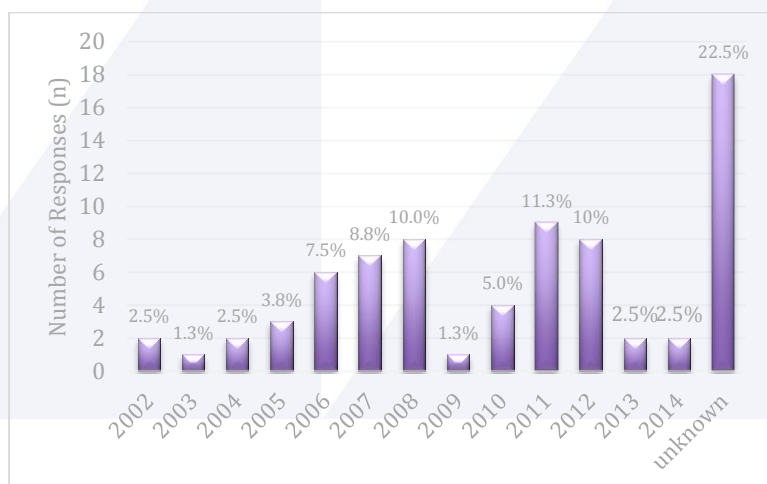


A comparison of the survey response rate with the original study cohort by gender is presented in the graph below.





Year commenced surgical training



Year commenced surgical training

Earliest	2002
Latest	2014
Mean	2008.8
Mode	2011
Median	2009
SD	3.0

Year withdrew from surgical training



Year withdrew from surgical training

Earliest	2006
Latest	2015
Mean	2011.1
Mode	2010
Median	2011
SD	2.2



Length of time spent in surgical training

The length of time respondents spent in training (years), based on the year of commencing training and the year of withdrawal, is presented in the graph below.

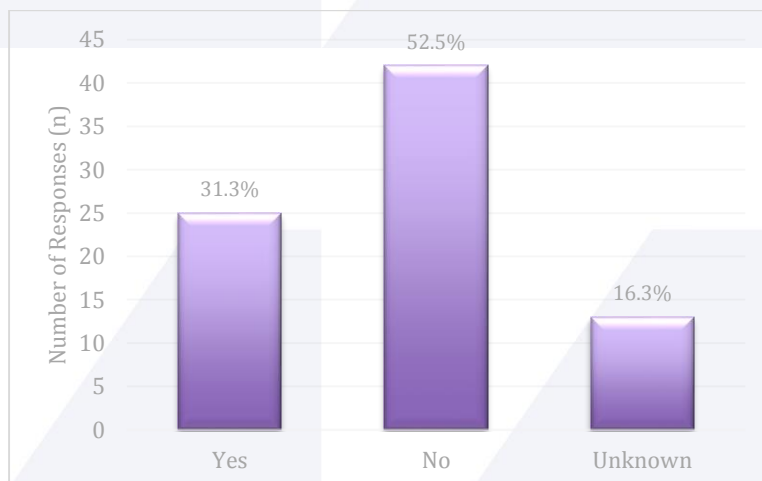


Length of time in surgical training

Min < 1 years
Max 10 years
Mean 2.6 years
Mode 1 year
Median 2 years
SD 2.0

Interruption from training

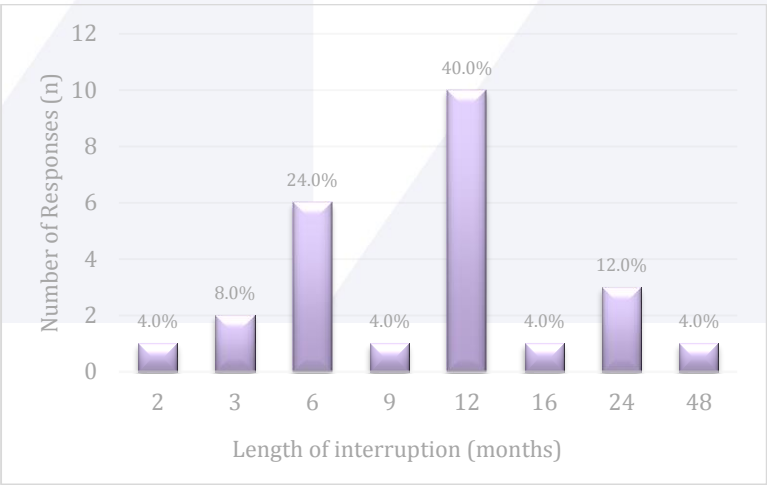
Respondents were asked whether they took an interruption from training. Their responses are graphed below.





Length of interruption from training

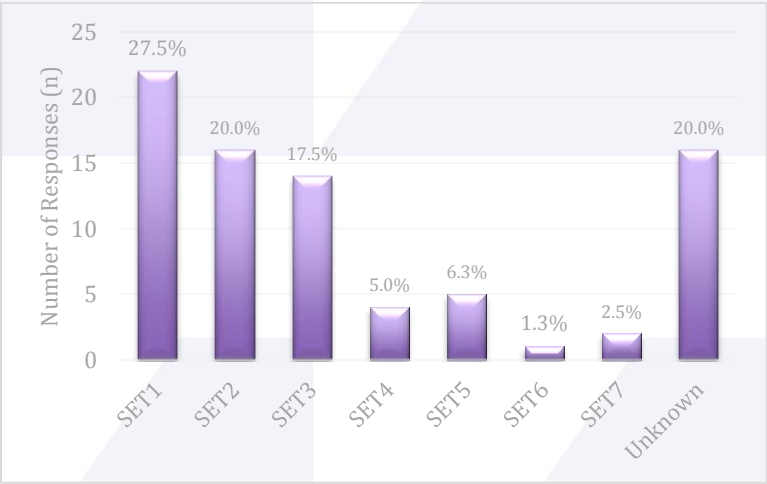
Of the twenty-five respondents that indicated they had formally interrupted from training, the duration of their interruption in months is presented in the graph below.



Interruption period (months)

Min	2 months
Max	48 months
Mean	12.4 months
Mode	12 months
Median	12 months
SD	9.6

Training level at time of withdrawal

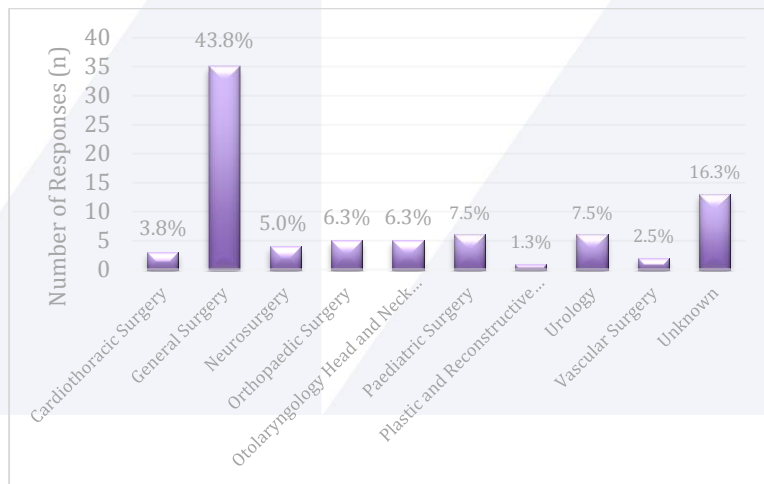


Training level at time of withdrawal

Min	SET 1
Max	SET 7
Mean	SET 2
Mode	SET 1
Median	SET 2
SD	1.54

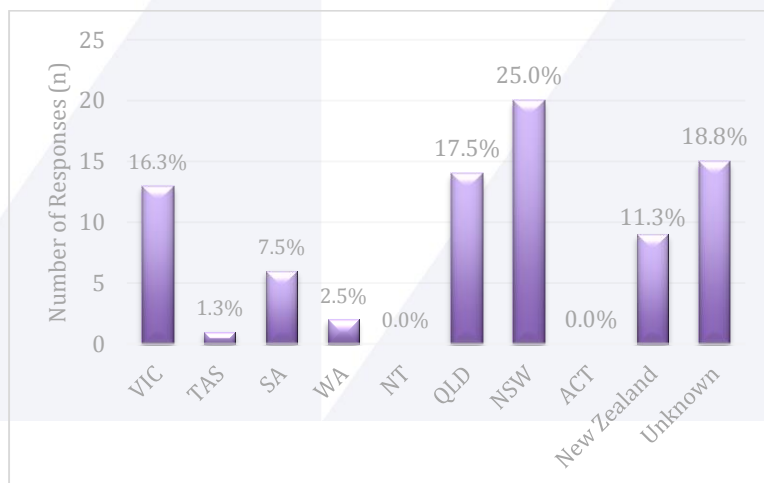


Primary Surgical Specialty

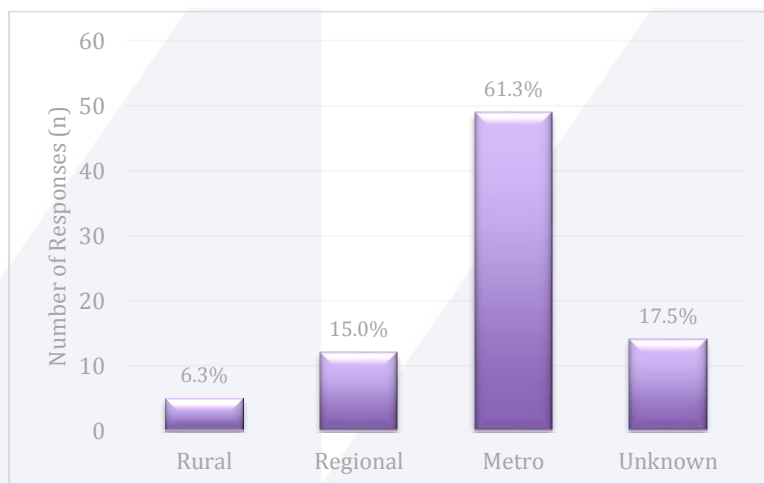


Location at time of withdrawal

Respondents indicated the state/region they were based at the time of withdrawal. Responses are presented in the graph below.



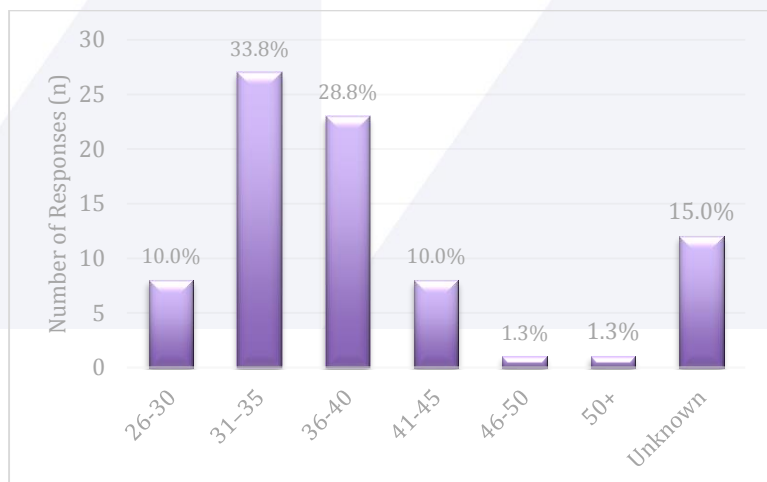
Respondents indicated the hospital type where they were based at the time of withdrawal. Responses are presented in the graph below.





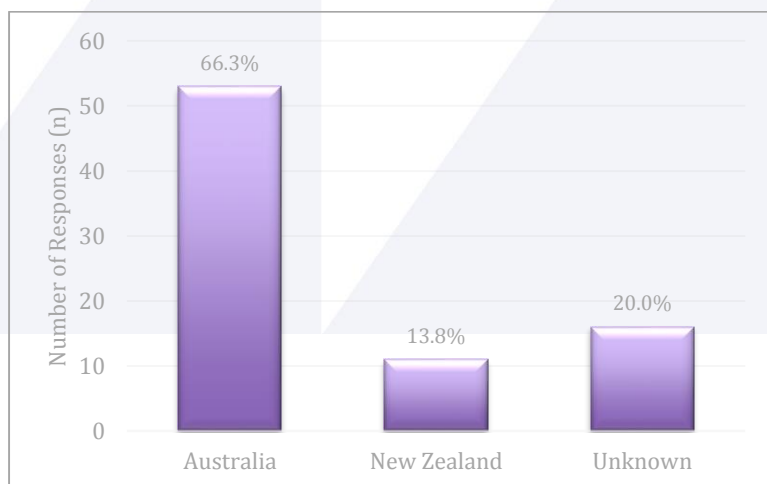
Age at time of withdrawal

Study participants gave their age range at the time of withdrawing. 62% withdrawing were in the age range 31 – 40 years.

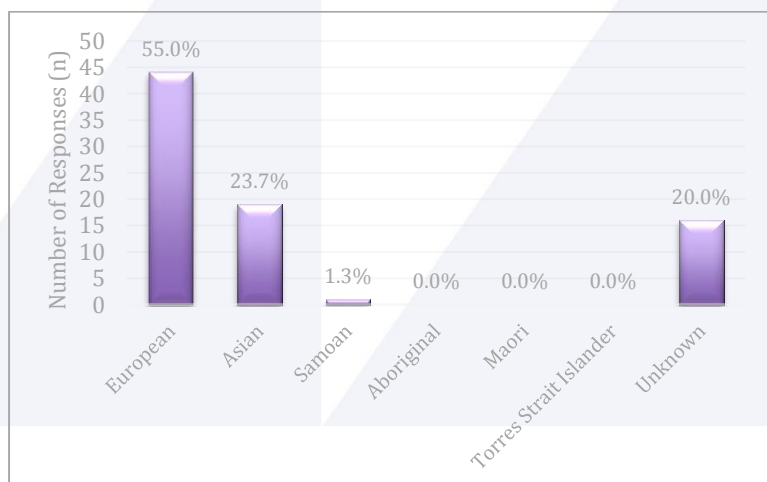


Citizenship

Study participants were asked if they were a citizen of Australia or New Zealand. Responses are presented in the graph below.



Ethnicity

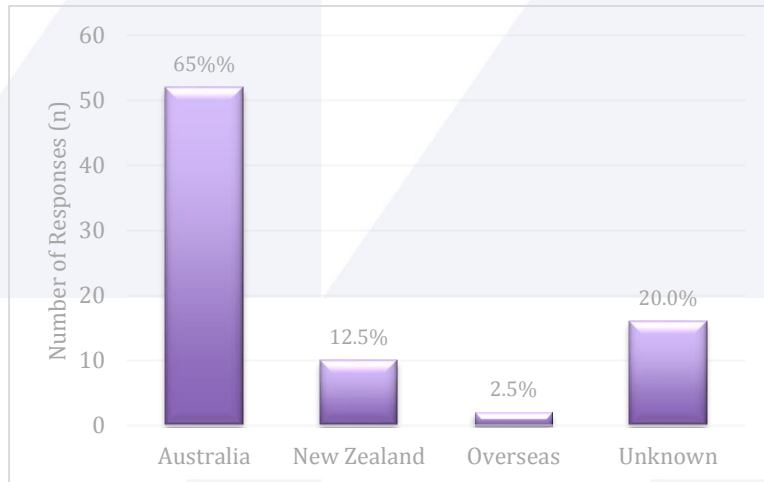




Primary medical degree

Survey responses related to primary medical degree are presented below.

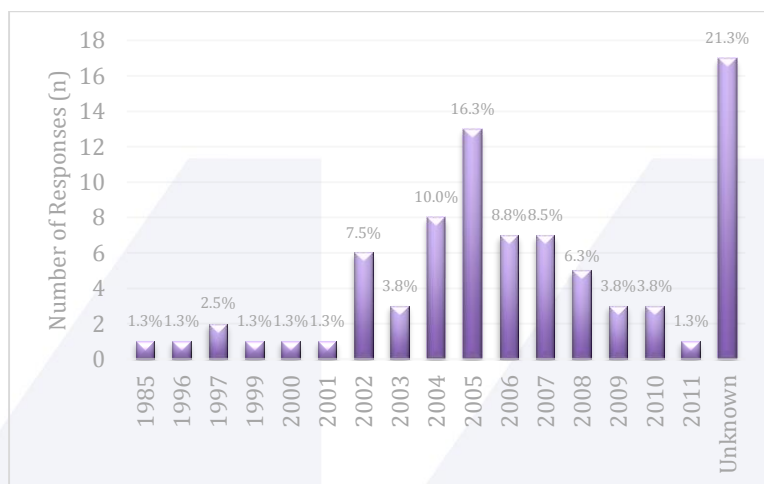
University Country



The five most frequent universities that respondents undertook their primary medical degree are listed in the table below.

Response category	Frequency Count = n (%)
University of Sydney	9 (11.3%)
University of Queensland	7 (8.8%)
University of New South Wales	7 (8.8%)
University of Otago	6 (7.5%)
University of Melbourne	5 (6.3%)

Year Primary Medical Degree Conferred



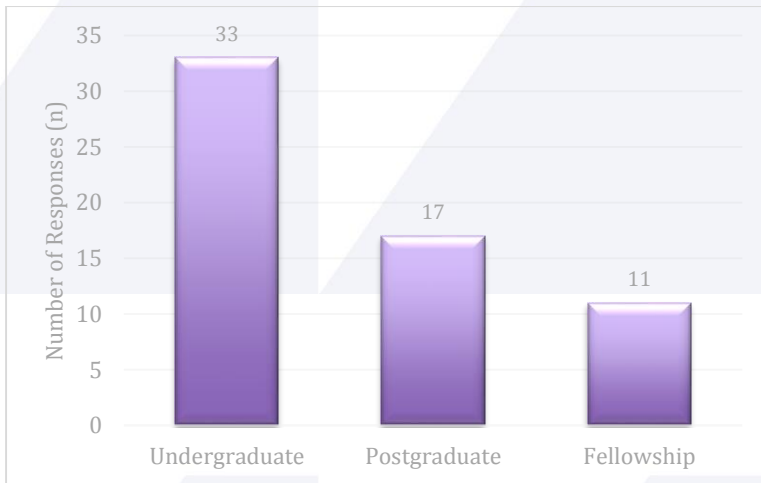
Year Primary Medical Degree conferred

Earliest	1985
Latest	2011
Mean	2004.6
Mode	2005
Median	2005
SD	3.99

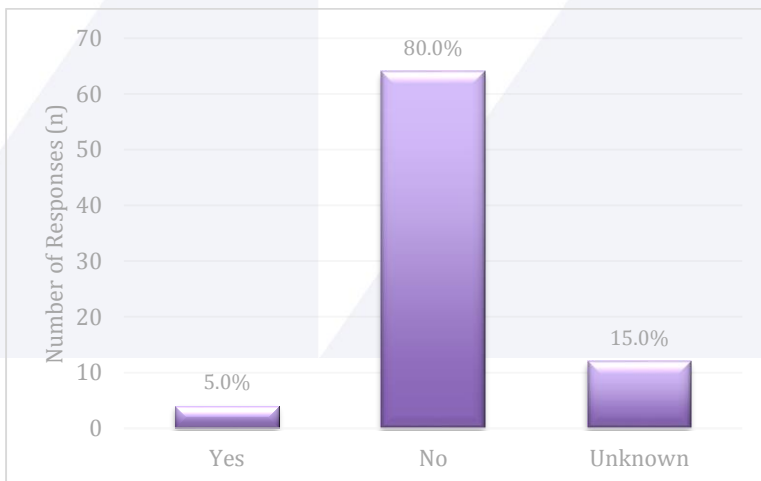


Other Qualifications

Survey participants were asked to specify any other qualifications. Forty-three participants responded to this question. Responses were categorised into other Fellowships, undergraduate and postgraduate qualifications and presented in the graph below.



Completion of the International Medical Graduate (IMG) Pathway prior to entry into surgical training





Post-surgical training activity

Sixty-seven respondents provided a free-text description outlining what they have done since withdrawing from training. The responses were categorised and presented in the table below. Note that respondents may have provided more than one response.

Response category	Frequency Count = n (%)
Fellow of the Royal Australian College of General Practitioners	15 (22.4%)
General Practice Trainee	3 (4.5%)
Emergency Medicine Trainee	8 (11.9%)
Fellow of the College of Intensive Care Medicine	2 (3.0%)
Intensive Care Trainee	7 (10.4%)
Fellow of the Royal Australian & New Zealand College of Radiology	5 (7.5%)
Radiology Trainee	3 (4.5%)
Physician Trainee	4 (6.0%)
Fellow of the Australian & New Zealand College of Anaesthetists	2 (3.0%)
Anaesthetics Trainee	1 (1.5%)
Fellow of the Australian College for Rural & Remote Medicine	1 (1.5%)
Fellow of the Royal Australasian College of Medical Administrators	1 (1.5%)
Medical Administration Trainee	1 (1.5%)
Completed non-surgical specialty training (unspecified)	9 (13.4%)
Completing a PhD	5 (7.5%)
Completing a Masters degree	4 (6.0%)
Postgraduate diploma	3 (4.5%)
Surgical Assisting	7 (10.4%)
Surgical Registrar	4 (6.0%)
Medical Educator	2 (3.0%)
Raising a family	8 (11.9%)
Taken time off	3 (4.5%)
Other (e.g. travelled)	5 (7.5%)

This question was explored further with interview participants.





Appendix F

Survey Analysis





F: SURVEY ANALYSIS

INTRODUCTION TO SURVEY ANALYSIS

A comprehensive analysis of the quantitative and qualitative survey responses has been undertaken.

Reporting

For reporting purposes the ordering and grouping of survey responses has been amended from the original survey order for coherence and grouping of themes and issues. The survey results are presented in the following categories:

- Reasons for Withdrawal from Training
- Exploring the process of withdrawal from training
- Evaluation of the overall training experience whilst in surgical training
- Evaluation of the overall assessment experiences whilst in surgical training
- Clinical Supervision and Mentorship
- Training Programme administration, organisation and governance.

Results are presented as frequency counts and / or percentages as appropriate for each survey item.

Sub-group analysis

Potential differences between sub-groups of survey respondents were explored using Analysis of Variance (ANOVA). For survey items where respondents were asked to report their level of agreement against four options from strongly disagree to strongly agree, responses were treated as a scale from 1 – 4 where 1 indicates strong disagreement and 4 = strong agreement.

Generally there were few differences between the group comparisons. As a result, only significant differences are reported in this section for ease of interpretation. Where a significant between group difference was identified they are listed with the associated frequency chart for the relevant survey item (with significance determined at $p \leq 0.05$).

The following comparisons were made and identified differences summarized.

- Gender: Comparing male and female responses
 - There were 4 significant differences (at $p \leq 0.05$) between these groups. These are described in the appropriate section of the analysis report.
 1. I wanted to change specialist pathways (e.g. surgery to anaesthetics) ($p=0.003$)
 2. I experienced discrimination ($p=0.026$)
 3. I found the information on training requirements was clear ($p=0.038$)
 4. Final outcome of the Clinical Exam ($p=0.025$)
- Fellowship of another College
 - Comparing those who had achieved a Fellowship with another College at the time of responding to the survey with those who hadn't.
 - There were no significant differences between these two groups.
- Interruption of training: Comparing the responses of those who took an interruption to training and those who did not.
 - There was 1 significant difference (at $p \leq 0.05$) between these two groups. This is described in the appropriate section of the analysis report.
 1. Number of attempts at the Clinical Exam ($p=0.022$)



- Length of interruption of training if taken: Comparing those who took an interruption of less than 12 months with those who interrupted training for 12 months or longer.
 - There were 4 significant differences (at $p \leq 0.05$) between these groups. These are described in the appropriate section of the analysis report.
 1. I wanted to change to a non-specialist medical career ($p=0.003$)
 2. I wanted to change to another surgical career (e.g. general to orthopaedics) ($p=0.026$)
 3. I was satisfied with the amount of clinical supervision / support provided ($p=0.038$)
 4. I felt supported by my supervisor(s) ($p=0.025$)
- General training versus other specialty training: Comparing those in general surgical training with those in another specialty branch of training.
 - This was the comparison set where the most between group differences were demonstrated. There were 9 significant differences (at $p \leq 0.05$) between these two groups. These are described in the appropriate section of the analysis report.
 1. I withdrew to avoid formal dismissal proceedings ($p=0.035$)
 2. I found that interactions I had with my RACS supervisors around my withdrawal to be positive ($p=0.039$)
 3. I initiated the withdrawal process ($p=0.001$)
 4. I was asked to consider withdrawal from the training programme by the specialty board ($p=0.006$)
 5. I was satisfied with the overall workload for training (including all assessment and placement requirements) ($p=0.008$)
 6. I was satisfied with my access to leave ($p=0.048$)
 7. I found that the level of responsibility I was given was appropriate ($p=0.004$)
 8. I felt supported by my supervisor(s) ($p=0.024$)
 9. I found my supervisor(s) to be professional ($p=0.008$)

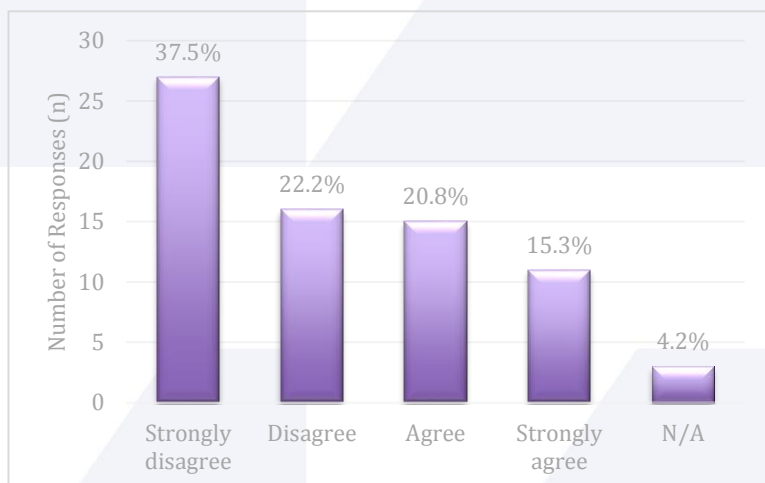
Due to the group number of respondents and spread of data no further comparisons could be made. Specifically it was not possible to compare different geographical regions for this cohort in a meaningful way. Due to the high level of geographical mobility amongst trainees, even with larger groups it would be very difficult to make meaningful comparison and to make any attempt to attribute an issue to a particular region in a study of this type.



REASONS FOR WITHDRAWAL FROM TRAINING

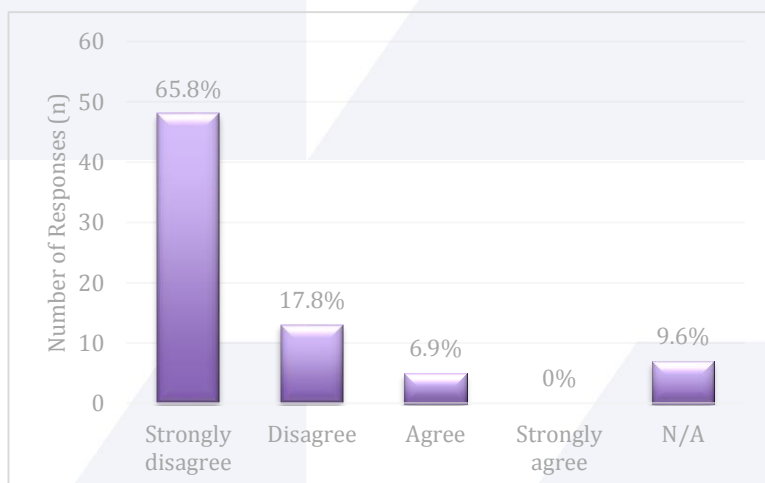
The following section of the survey explored reasons for leaving the surgical training programme in a structured fashion asking respondents to rate their level of agreement or disagreement with a range of statements. Frequency charts showing the proportion of agreement and disagreement or not applicable responses [N/A] with all the factors provided are shown below.

I wanted to change specialty pathways (e.g. surgery to anaesthetics)



There was a gender difference in the responses to this item. Women were less likely than men to report agreement that they withdrew from training in order to change specialty pathways ($p=0.003$).

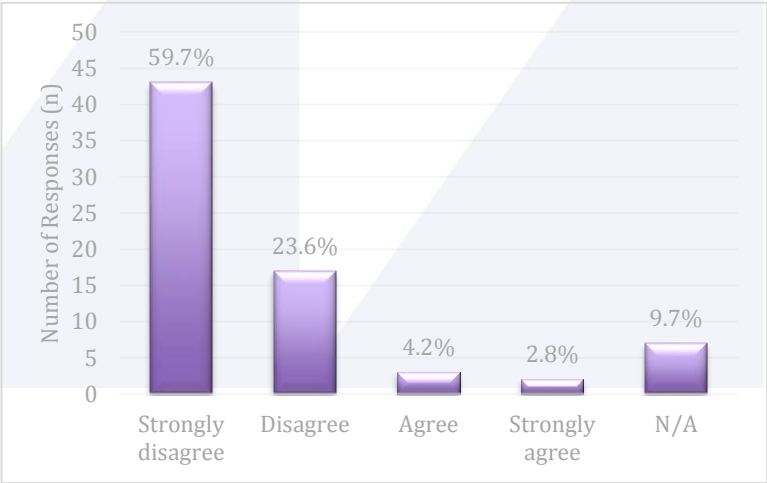
I wanted to change to a non-specialist medical career



There was a difference between the responses of the two groups of respondents who interrupted from training for less than 12 months or 12 or more. The group who interrupted for 12 months or more were in stronger agreement that they wanted to change to a non-specialist medical career ($p=0.003$).

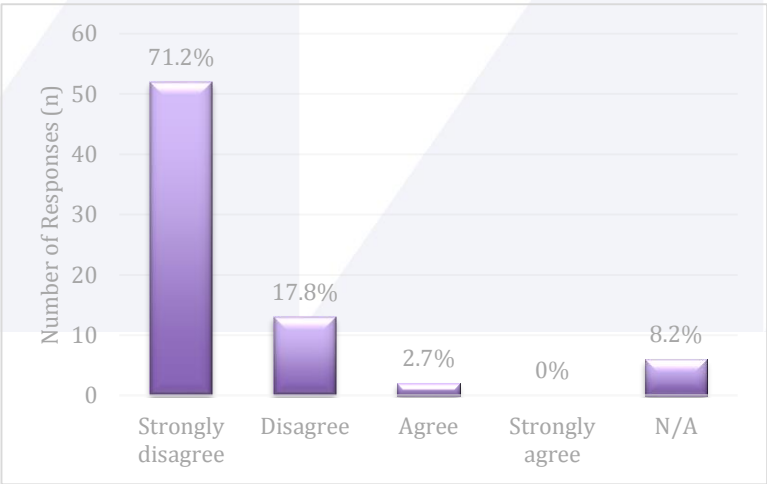


I wanted to change to another surgical career (e.g. general to orthopaedics)

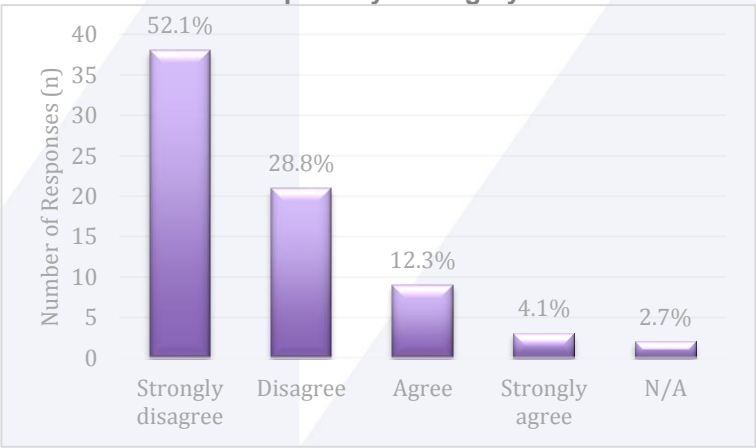


There was a difference between the responses of the two groups of respondents who interrupted from training for less than 12 months or 12 or more. The group who interrupted for 12 months or more were less likely to be in agreement that they wanted to change to another surgical career ($p=0.026$).

I wanted to change to a non-medical career

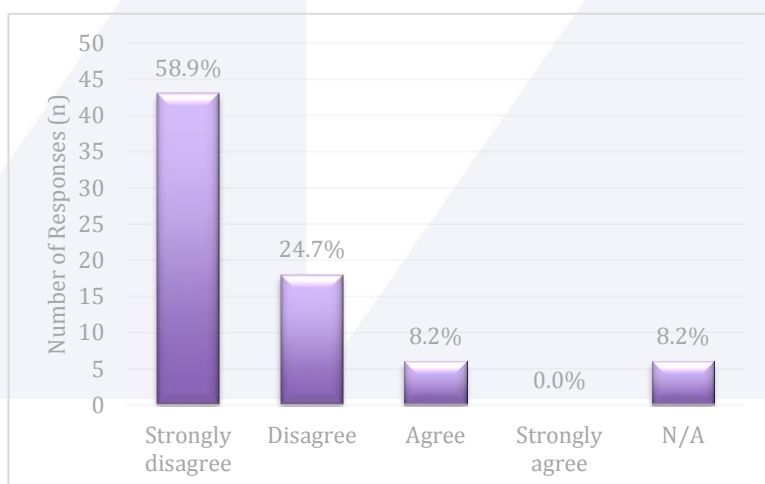


I lacked technical competency in surgery

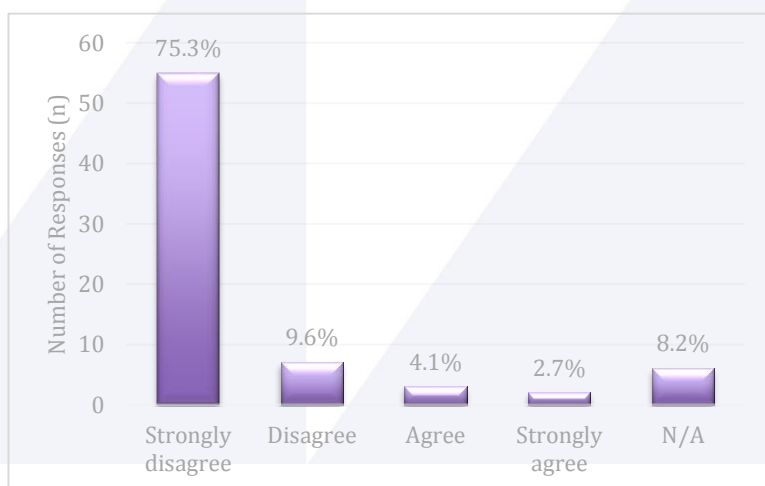




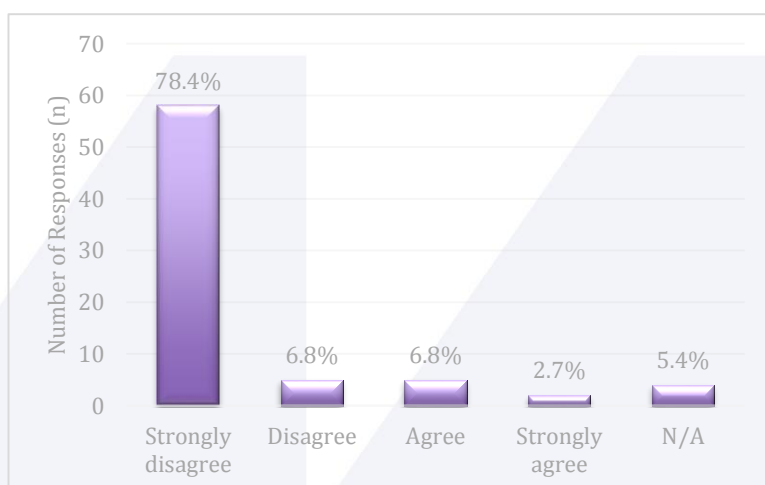
I experienced adverse patient outcome(s)



I withdrew to maximise my chances of completing training at a later date



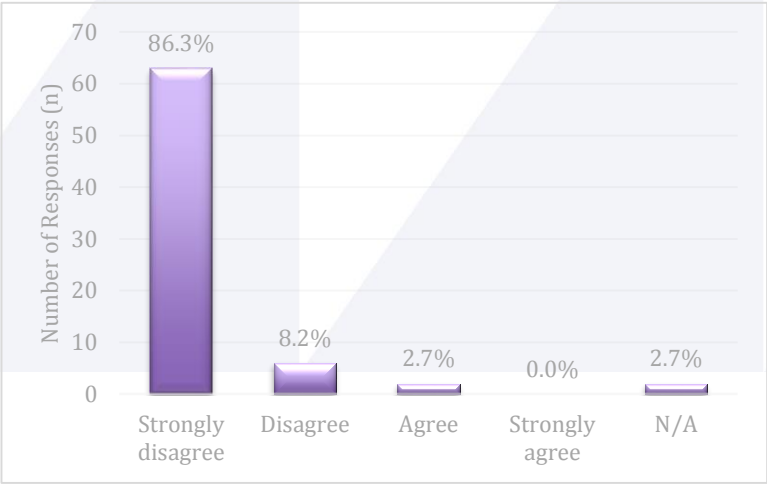
I withdrew to avoid formal dismissal proceedings



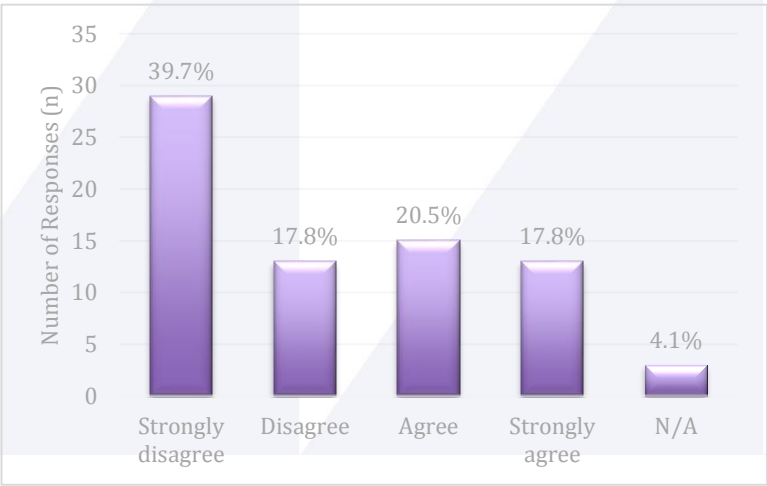
There were between group differences for those who were undergoing general surgical training and other specialty training. The group in general surgical training were less likely to be in agreement that they withdrew to avoid formal dismissal ($p=0.035$).



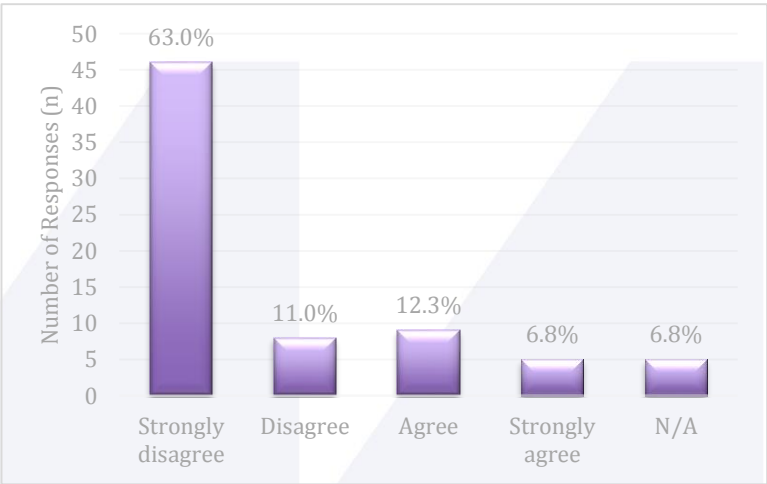
I had financial considerations / constraints



I had family / carer commitments

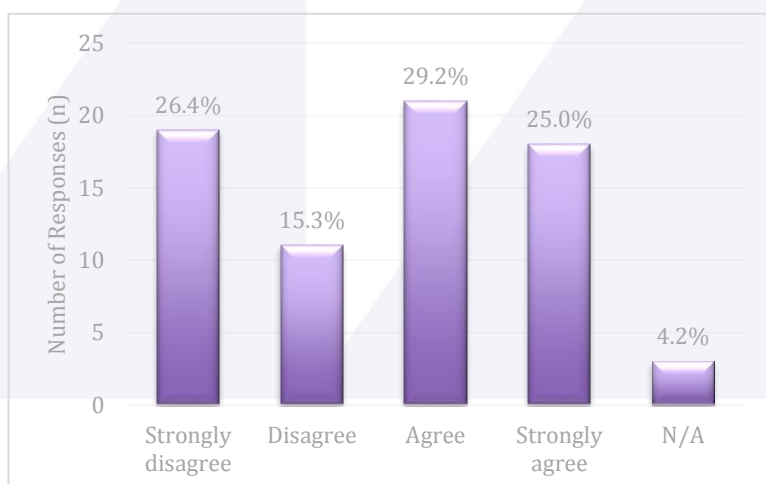


I experienced health issues

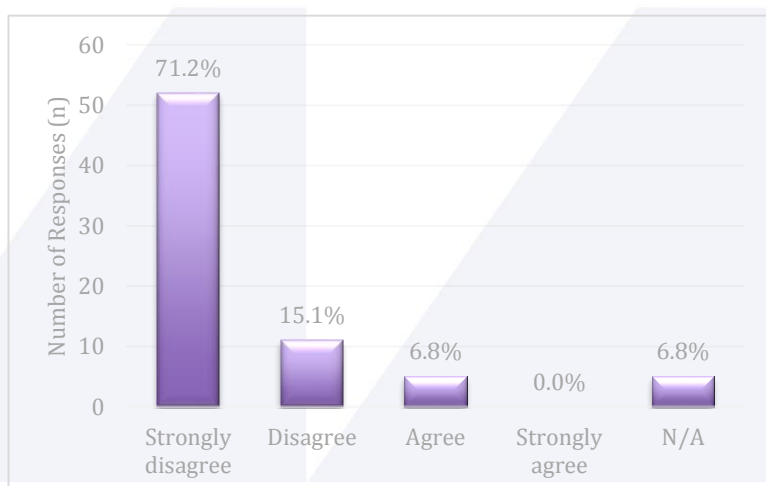




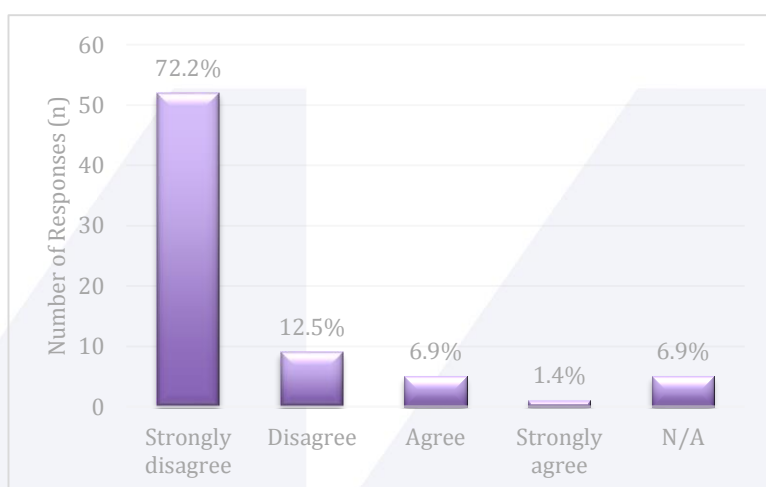
I felt I was burned out



I had unsuccessful exam outcome(s)

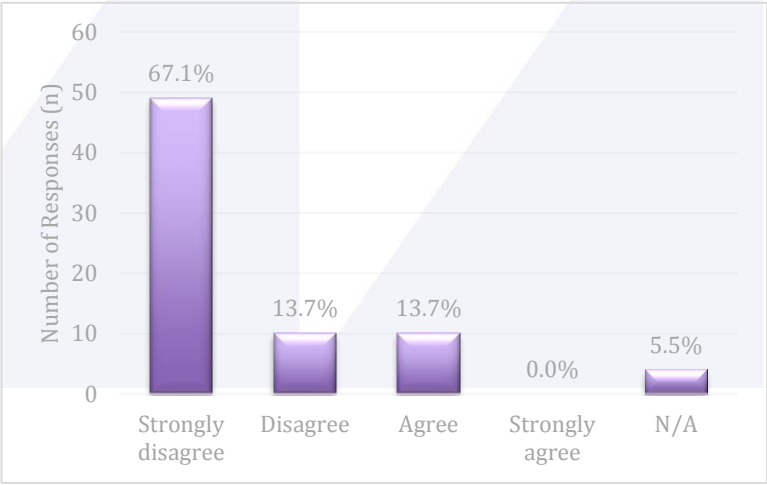


I was expecting unsuccessful exam outcome(s)

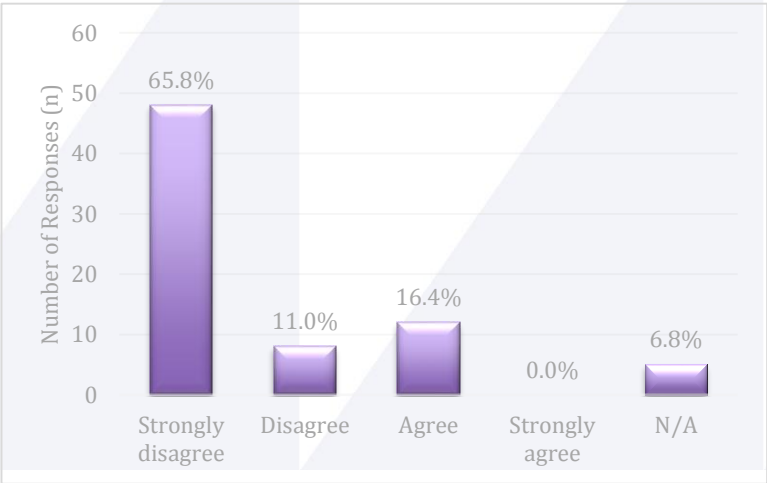




I had unsuccessful training / clinical assessment outcome(s)

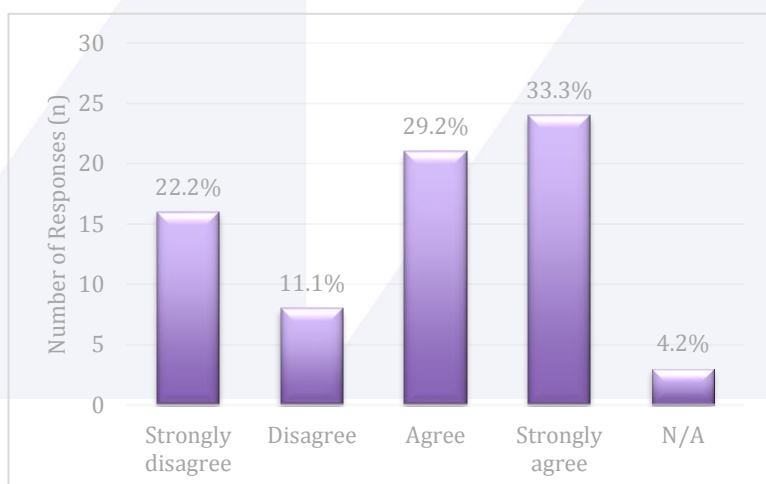


I was expecting unsuccessful training / clinical assessment outcome(s)

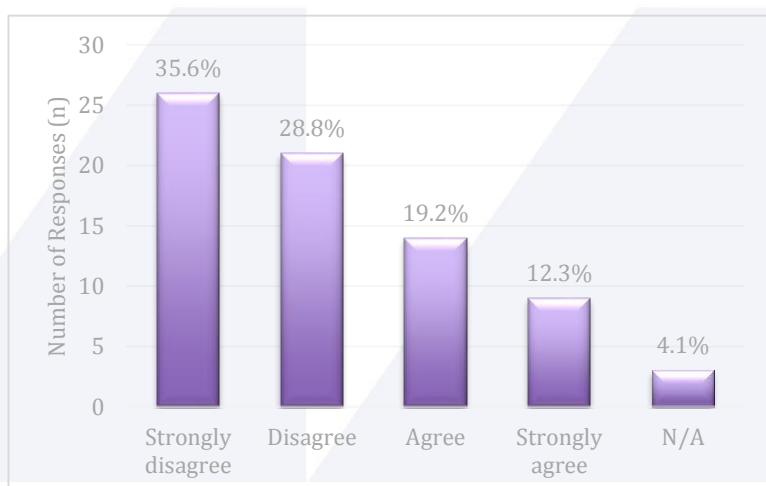




I experienced bullying

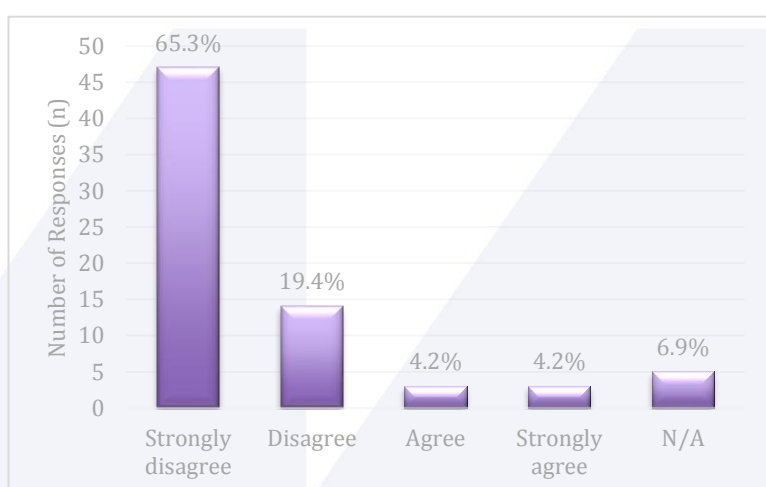


I experienced discrimination



There was a gender difference in the responses to this item. Women were more likely than men to report that they agreed experiencing discrimination ($p=0.026$).

I experienced sexual harassment





Qualitative survey responses outlining the reasons for withdrawal

Sixty-six trainees provided a free-text description describing, in their own words the main reasons and circumstances that led to them withdrawing from the Surgical Training Programme.

A thematic analysis of the responses describing the main reason(s) and circumstances leading to withdrawal from surgical training was undertaken. The table below outlines the categories used for the thematic analysis as well as sample representative comments from survey respondents to this survey question.

Response Category	Frequency Count (n)	Representative comment/s
Significant training/work hours required and the on-call commitments (including part-time training not preferred)	24	<p><i>Brutal on-call roster (1 in every 2 days), lack of sympathy from consultants regarding the onerous on call commitments, lack of support for study leave to undertake the primary examinations. [Survey respondent 53]</i></p> <p><i>Surgical training is arduous, as I had expected and prepared myself for. However, I found it particularly challenging without my usual support network around me, and working long hours with 1 in 3 on call and the constant fatigue all surgical trainees experience leaves little time and energy to develop establish a new life/friends. [Survey respondent 63]</i></p> <p><i>Extreme time committents [sic] that would have been required to complete the surgical training. Difficulty in finding work life balance. [Survey respondent 80]</i></p>
Experienced bullying, discrimination and/or harassment	24	<p><i>In summary, I suffered systematic bullying, of a mental, physical and sexual nature, from the beginning of my training. Day in, day out, I was told I was going to 'kill the patient'. [Survey respondent 2]</i></p> <p><i>Bullying, harassment, over-worked, under-trained, under-supported, humiliated. A combination of the above factors led me to leave a male-dominated work environment and contemplate quitting medicine altogether. [Survey respondent 36]</i></p> <p><i>The culture of bullying that was entrenched in the [surgical specialty] world, across different hospitals. This resulted in inadequate training being provided. [Survey respondent 79]</i></p>
Feeling unsupported by supervisors	19	<p><i>Ultimately the biggest factors were feeling unsupported by consultants at work and a culture that made me feel that in trying to stand up for myself, other trainees and the safety of my patients I would be seen as some kind of whistle-blower. [Survey respondent 12]</i></p> <p><i>- unsupportive environment especially when requesting for help from the on-call surgeon.</i></p> <p><i>- hierarchical behaviours/attitudes from surgeons and surgical trainees.</i></p>



Response Category	Frequency Count (n)	Representative comment/s
		<ul style="list-style-type: none"> - difficult to bring up surgical training issues with superiors as it has implications on career/training pathway. - lack of mentorship/leadership from surgeons I interacted with, the surgeons were not interested in their work or teaching me. - resistance of change in unprofessional behaviours in the surgical field. [Survey respondent 37]
Inadequate surgical training provided by training institution/s	16	<p>I became very disillusioned with surgical training during my first year of advanced surgical training. The consultants I was working for did not provide training and were very poor role models. [Survey respondent 14]</p> <p>Disappointment at the trainers and the process of training. [Survey respondent 26]</p>
Family/lifestyle commitments	16	<p>I loved surgery but I also had a 2 year old child. Training as a young mother was proving to be too traumatic for my son and for me. The long hours, the stressful on-call, the lack of support from my senior registrars as a trainee, and the disapproval and judgemental nature of my consultants due to the fact I was so junior all took a toll and were the reasons I withdrew. [Survey respondent 55]</p> <p>The lifestyle and working hours were another deterrent [sic]. I did work very hard as a registrar- up to 72 hours on call over some weekends and I wouldn't get much sleep. I realised that I didn't want to constantly be woken up during the night and have to come into hospital (however this would lessen when I would have been a consultant and I perhaps didn't appreciate this at the time). [Survey respondent 33]</p>
Poor support and lack of transparency from the College or Boards regarding education, training and remediation requirements	13	<p>The training assessments for the college were a source of power for the consultants and it was difficult to glean meaningful feedback while constantly in fear of getting a surprise unsatisfactory assessment from a rogue or bully consultant. These assessments and the board interviews were always a scary occasion as the focus was more on 'who would be getting kicked off the program' rather than trying to get us to perform to the best of our ability. [Survey respondent 69]</p> <p>I felt that there was lack of basic ethical principals [sic] of justice as a prejudgement was made by my committee well before a meeting was held. [Survey respondent 29]</p>
Inability to undertake training in preferred training placements/regions	12	<p>The immediate precipitant for my withdrawal was prospect of being moved interstate. I was aware of interstate movement when I commenced SET training, but indications were that it was typically for 2,</p>



Response Category	Frequency Count (n)	Representative comment/s
		<i>sometimes 3, rarely more than 4 years of training. At the time of withdrawal I had completed four years of training interstate and was being told I had to complete 5 and likely 6 years interstate (in 2 new locations). While I understand the benefits of broad geographical training, I was finding the constant moves were directly disruptive to my training in addition to being very disruptive to family life, and of course financially/socially disruptive. [Survey respondent 6]</i>
		<i>Being unable to predict where I would be placed or have any influence over where I would be sent, and therefore knowing that I could not arrange to live a commutable distance from my partner for a number of years. [Survey respondent 39]</i>
Experienced health issues including burnout, stress, depression	12	<i>Going to work every day was a misery. It affected my health and my relationship. [Survey respondent 64]</i> <i>Emotional burn-out due to long working hours, the stress of unnecessarily critical supervisors and in some cases bullying behaviour, as well as knowing that my skills were not improving to a standard appropriate to my stage of training. [Survey respondent 39]</i>
Had or expected an unsuccessful training/clinical assessment outcome(s)	11	<i>I felt if I did not resign I would be thrown out. [Survey respondent 54]</i> <i>On placement to a new centre, within the first 3 months I started to receive poor performance reviews. I left a training centre where my performance reviews included "exceptional" in some areas that were now being rated borderline. Although I continued to rate poorly I was never set up with a clear pathway towards improving feedback. I would ask how I came to get these marks, but received answers that "this simply reflected my lack of insight that I couldn't see what was wrong". I was instructed to see a psychologist and when the report returned without any concerns this was never referred to again. [Survey respondent 30]</i>
Lack of flexibility in training (inability to undertake training in other areas such as research, public health, lack of study leave time available and leave requests declined/exceeded)	10	<i>I found the training program lacked flexibility. I also have concurrent vocational interest in public health and health systems, an interest and skill set I intended to bring back to surgery. [Survey respondent 17]</i> <i>I couldn't take any further time off the programme without breaking the rules on how long the training post should last. [Survey respondent 23]</i>
Preference for another medical specialty	9	<i>I wanted to change specialist pathways after realising that surgery was not the right fit for me. [Survey respondent 74]</i>



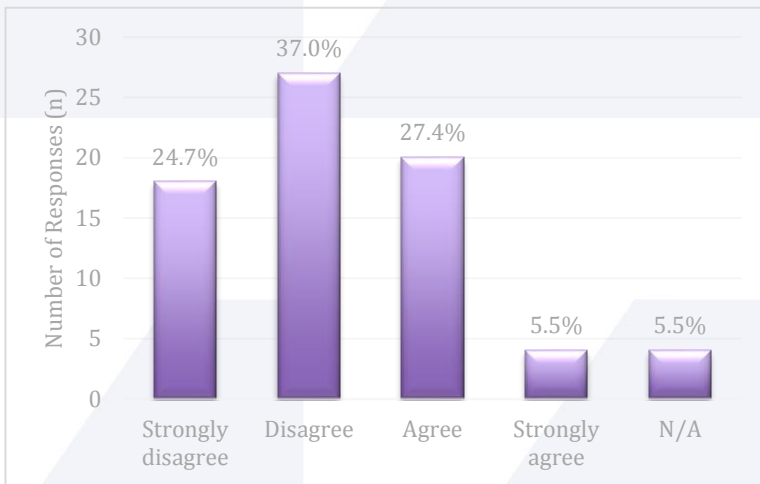
Response Category	Frequency Count (n)	Representative comment/s
		<i>Decision to change specialities - personally I loved surgery but felt due to training requirement and long-term prospects this was ultimately not the best specialty choice for me. [Survey respondent 16]</i>
Lack of senior role models to aspire to	6	<i>I found it difficult to identify senior colleagues who I aspired to be like. [Survey respondent 13]</i>
Lacked technical competence in surgery	4	<i>Mediocre Surgical Skills. [Survey respondent 5]</i>
Other	9	<i>No comments. [Survey respondent 77]</i>



THE PROCESS OF WITHDRAWING FROM SURGICAL TRAINING

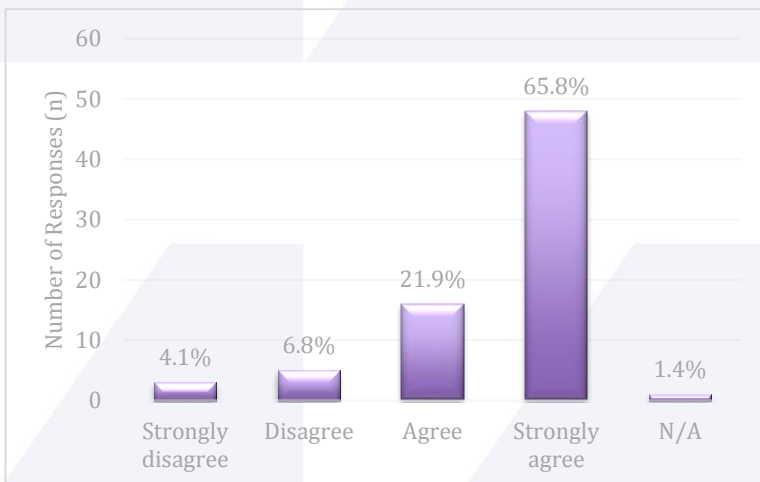
Trainees who have had the experience of withdrawal from training are well-placed to report on their perceptions of this experience. Doing so may enable practical improvements to be made. This section of the survey related to the experience and processes of leaving the training programme. Frequency charts showing the proportion of agreement and disagreement or not applicable responses [N/A] are shown below.

I found that interactions I had with my RACS supervisors around my withdrawal process to be positive



There were between group differences for those who were undergoing general surgical training and other specialty training. The group in general surgical training were more likely to be in agreement that the interactions they had with RACS supervisors around withdrawal were positive ($p=0.039$).

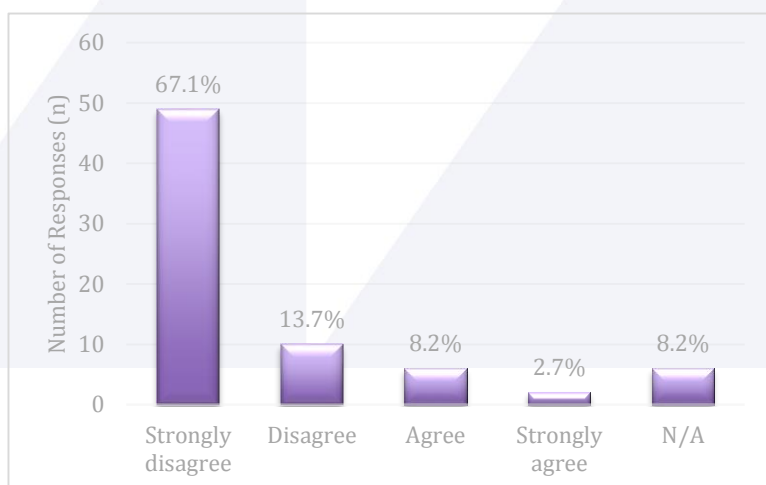
I initiated the withdrawal process



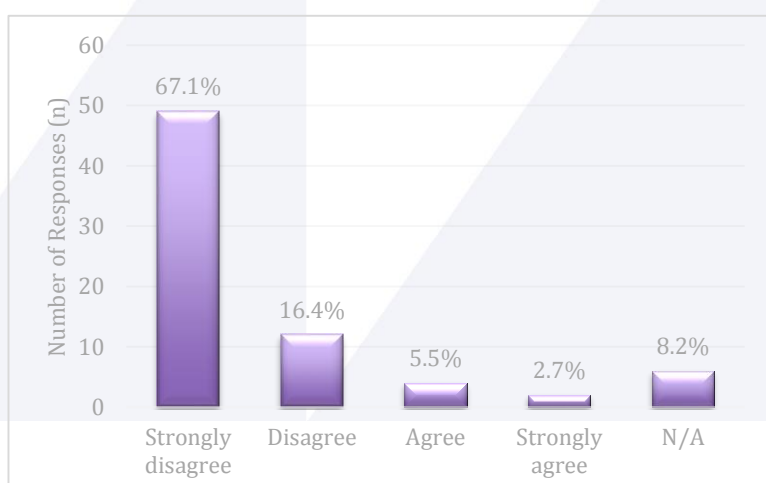
There were between group differences for those who were undergoing general surgical training and other specialty training. The group in general surgical training were more likely to be in agreement that they initiated the withdrawal process ($p=0.001$).



I was asked to consider withdrawal from the training programme by a supervisor / colleague



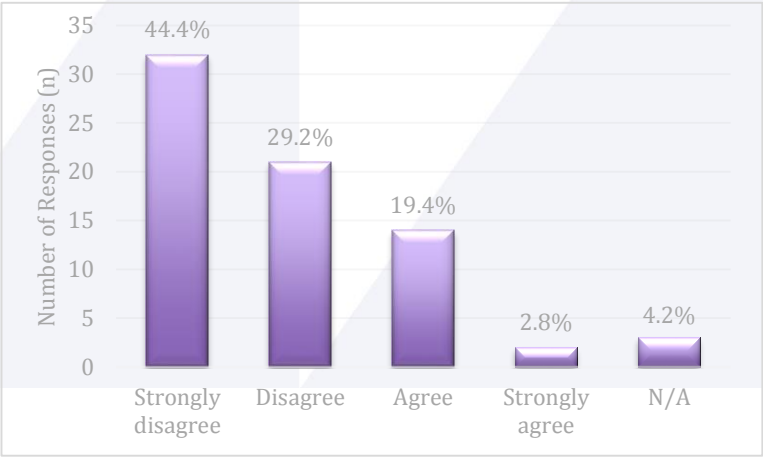
I was asked to consider withdrawal from the training programme by the Specialty Board



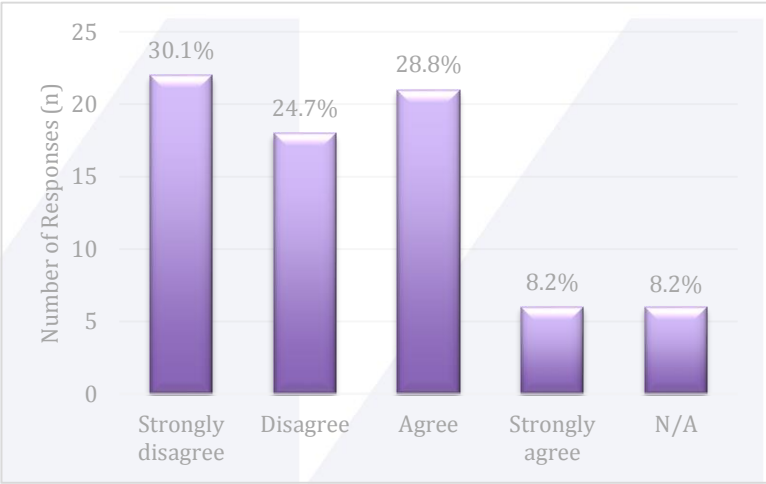
There were between group differences for those who were undergoing general surgical training and other specialty training. The group in general surgical training were less likely to be in agreement that they were asked to consider withdrawal from the training programme by the Specialty Board ($p=0.006$).



I felt supported to make the right decision regarding my training



RACS managed my withdrawal sensitively





Qualitative survey responses outlining what could have been done to prevent withdrawal

A thematic analysis was undertaken of the seventy responses describing what, if anything, could have been done to prevent withdrawal from training. The table below outlines the categories used for the thematic analysis as well as sample representative comments from survey respondents to this survey question.

Response Category	Frequency Count (n)	Representative comment/s
Increased provision of leave/interruption/flexibility/part-time work in training	15	<p><i>Part time training or job share. Allowing an extended break from training. [Survey respondent 49]</i></p> <p><i>Possibly taking a break from training to recover from burn-out could have prevented withdrawal. However, in retrospect, withdrawing was the absolute right choice for me. [Survey respondent 62]</i></p>
More supportive training environment including reasonable work/life balance	15	<p><i>Showed at least some ounce of encouragement or support with provision of services for trainees who were struggling to deal with the surgical culture. [Survey respondent 36]</i></p> <p><i>If I had a more supportive training environment and a bit more sense of work-life balance then I wouldn't have got burnt out. If RACS supervisors had been supportive when I expressed thoughts about withdrawing then maybe I could have been [sic] resolved my concerns and continued in training. Rather when I expressed concerns the attitude was "if you don't like it, get out" [Survey respondent 13]</i></p>
Amendments to the training placement process allocations based on trainee preference, reduction in the number of training placements required to increase work/training stability and pre-assign locations at commencement of training	14	<p><i>Realistic expectations of time spent away at the early stages of training should be communicated. Things may have been different if we knew from the outset that 3 of the first 4 terms would have been at a rural centre as my wife could have planned appropriately. But only finding out about term allocations in the preceding November did not give enough time for adjustments to be made by spouses. Our anxieties were further increased by expecting that I would have been sent to a rural centre for at least 6 months of [SET] - which would have meant 2.5 years out of 3 spent living apart from my wife in the first 3 years of our marriage. [Survey respondent 61]</i></p> <p><i>Adopt a policy similar to the O&G college and notify trainees where there [sic] rotations will be for the first years of their training - no last minute job and location changes at least allows for better family/life planning. [Survey respondent 32]</i></p>
Improved formal and informal support from supervisors	12	<p><i>Better mentoring and supervision may have affected my decision to leave. [Survey respondent 44]</i></p> <p><i>More formal and informal support from supervisors. [Survey respondent 1]</i></p>



Response Category	Frequency Count (n)	Representative comment/s
Provision of a culture free of bullying and sexual harassment	11	<i>Be treated with respect, not to be yelled at by consultants, not to be called "stupid woman" by the most senior specialist and when complained, was told: oh don't worry he is always like that. The list of examples goes on and on. [Survey respondent 76]</i> <i>Providing me with an environment free from constant belittling and sexual harassment. [Survey respondent 2]</i>
Nothing could have been done to prevent withdrawal	9	<i>Nothing. My decision to pursue a different specialty was something I had considered for a very long time. [Survey respondent 72]</i> <i>Nothing - the main driver behind the decision was to be able to spend more time with my family in the future. [Survey respondent 71]</i>
Improved support systems available at the College	8	<i>If someone from the college had contacted me, discussed my options, discussed what the rest of the training program would be like and explained how a surgical career could suit the my [sic] lifestyle, or how I could deal with some of the issues that I felt were overwhelming my decision making, maybe I would not have left. [Survey respondent 66]</i>
Removal of specific supervisors/placements identified as not providing appropriate training	7	<i>1) Not having placements where the supervisor is known not to provide supervised operative experience to the trainee. 2) Not having placements where much of the consultant service is provided by locums or various short-term supervisors. [Survey respondent 39]</i>
Improved fairness and transparency around the selection and assessment processes	6	<i>Stop changing the exam policy every year. Stop changing the selection criteria every year. Stop changing the interview process every year. More feedback for specialty exam paper results. [Survey respondent 31]</i>
Clearer communication to trainees regarding training requirements from both College and supervisors/trainers	5	<i>Consistent information provided by the trainers. [Survey respondent 7]</i>
Access to an independent party to discuss training options and supports available	5	<i>Having perhaps someone from RACS to discuss my issues with training privately to help come to some sort of resolution. [Survey respondent 47]</i>
Increased access to training in technical competence and non-clinical skills	4	<i>Assistance learning non-clinical skills required as a trainee (resource management, assertiveness), clearer communication around training requirements between supervisors of training and me. [Survey respondent 7]</i>
Improved recognition of prior learning processes	2	<i>Recognition of work undertaken that was profoundly contributory to my surgical skills, however did not meet the structure of the training program. [Survey respondent 17]</i>
Other	10	<i>With several years of unaccredited surgical training under my belt, prior to commencing formal training, I believe I could have been trained as a competent surgeon. [Survey respondent 42]</i> <i>Too many things. [Survey respondent 68]</i>



Qualitative survey responses of additional comments regarding withdrawal from training

A thematic analysis of the fifty-one additional comments regarding withdrawal from the surgical training programme was undertaken. The table below outlines the categories used for the thematic analysis as well as sample representative comments from survey respondents to this survey question.

Response Category	Frequency Count (n)	Representative comment/s
Disappointment with support provided by the College	11	<p><i>The college never reached out to help in any way. What I wanted was some perspective, some idea as to whether I was viewing the decisions from a point-of-view of reality or from an unhealthy view that had been ruminating in my mind; focusing too much on the negatives.</i> [Survey respondent 66]</p> <p><i>I found the college rude, condescending, insensitive and an old mans club full of people who seemed to make it their mission to prove that you will never be as good as them. Constant hoop jumping with no recognition for the hard work and dedication trainees put in on a daily basis. They did it tough so everyone should.</i> [Survey respondent 19]</p>
Disappointment at leaving the surgical programme	10	<p><i>I loved surgery, I still miss it and to this day and [sic] have deep regret about the career I lost.</i> [survey respondent 27]</p> <p><i>I feel that leaving the program has been one of the hardest, if not hardest, decisions of my life.</i> [Survey respondent 66]</p>
Unsupportive culture in training including bullying and harassment	10	<p><i>There is a definite element of female discrimination within surgical training making this a less desirable field of work.</i> [Survey respondent 32]</p> <p><i>It was not the work that drove me to withdrawal, it was the unsupportive culture, the bullying, the lack of care that consultants had for their trainees. Senior trainees mimicked this by flogging junior trainees on the roster and belittling them when they asked for help. The high pressure work I enjoyed. I was good with my hands, passed my exams and received good feedback. The work wasn't the problem, it was the people. I didn't want to end up like them.</i> [Survey respondent 13]</p>
Positive comments about no longer being on the surgical programme	8	<p><i>I am so glad I left. I wish I never had anything to do with RACS. I wish it never happened. I pretend it never did.</i> [Survey respondent 2]</p> <p><i>I will never regret leaving SET but I regret the way I was treated during the surgical training process. I can only hope that RACS takes this feedback on board and provides a safer and more supportive training</i></p>



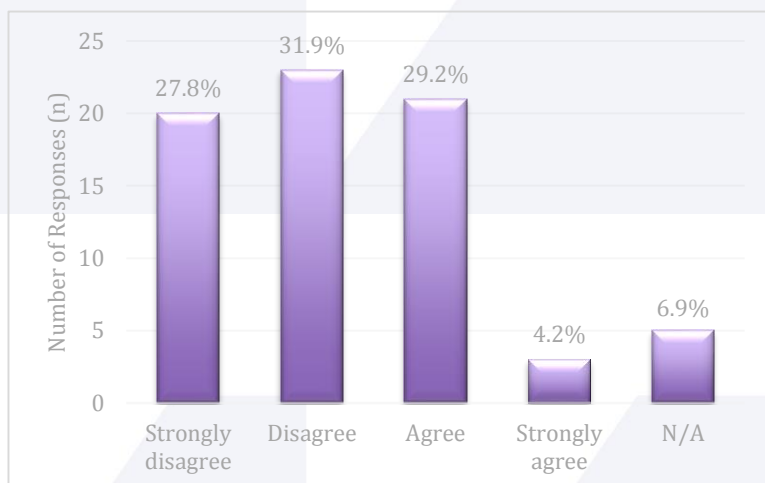
Response Category	Frequency Count (n)	Representative comment/s
		<i>environment for future trainees. [Survey respondent 36]</i>
Positive comments regarding the withdrawal process overall	7	<i>RACS was discreet and the process was not difficult or challenging. I was supported from RACS, but not from the surgeons i [sic] worked with. [Survey respondent 75]</i> <i>My supervisors and the college were very supportive of my decision and I am grateful for that. I was not made to feel guilty for choosing another specialty. [Survey respondent 74]</i>
General negative comments regarding the surgical training programme overall	6	<i>I felt at the time it was unreasonable and inflexible. [Survey respondent 21]</i>
Loss of interest in surgery as a career or positive experiences with a change in career	5	<i>Couldn't be happier in ACEM and CICM! Colleges with much more supportive programs, and workplaces within training that are much more supportive. [Survey respondent 25]</i>
Experiences of unprofessional behaviour by supervisors	4	<i>Consultants arguing/undermining each other. Consultants undergoing anger management training. Consultants actually coming to physical blows. [Survey respondent 68]</i>
Lack of transparency and support from the Board	3	<i>In general I found the board did incredibly little to actually assist me in my training and was just keen to meddle from long-range. [Survey respondent 6]</i>
Negative comments regarding the assessment process	2	<i>My board of training was obsessed with the relentless collection of trainee assessment data, with constant MiniCEX/DOPS/ self assesments [sic] etc. The volume of time devoted to this paperwork is considerable, both for board and trainee. [Survey respondent 7]</i>
Positive comments regarding the assessment process	1	<i>Prior to/during my time in training the exams process was heavily altered. My experiences of pre-fellowship examinations and my training for the fellowship exams gave me a very positive view of the examinations process. [Survey respondent 6]</i>
Other	8	<i>I only feel comfortable providing this honest feedback now that I am 'safely' on another training program. [Survey respondent 69]</i> <i>I was given different feed backs [sic] from different trainers. Some was [sic] shocked by my withdrawal and asked me not to do so as I am [sic] doing well. While others who attended the board meeting told me that they indicated otherwise in the meeting. No one [sic] department was willing to accept my resignation letter. [Survey respondent 26]</i>



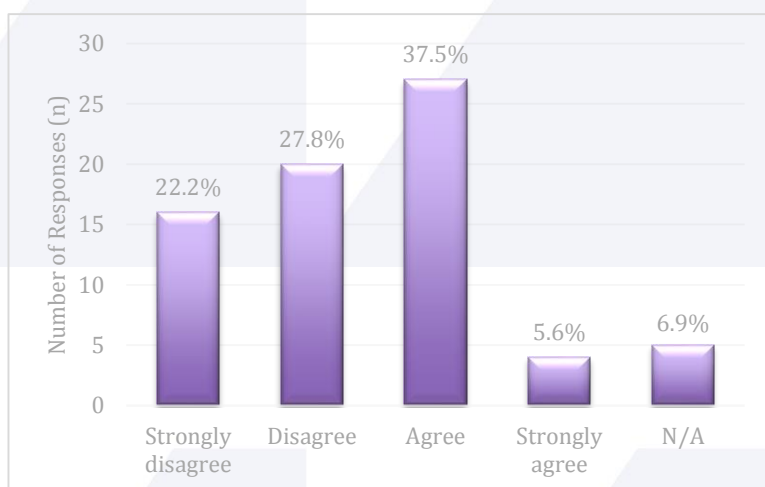
OVERALL TRAINING EXPERIENCES

This survey section collected participant evaluations of their overall training experience (including assessments) and general placement experience. Frequency charts showing the proportion of agreement and disagreement or not applicable responses [N/A] are shown below.

I was satisfied with the training programme overall



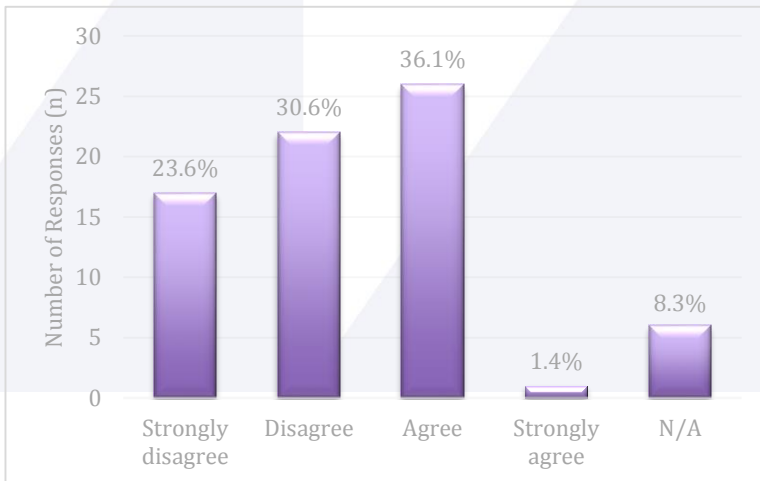
I was satisfied with the overall workload for training (including all assessment and placement requirements)



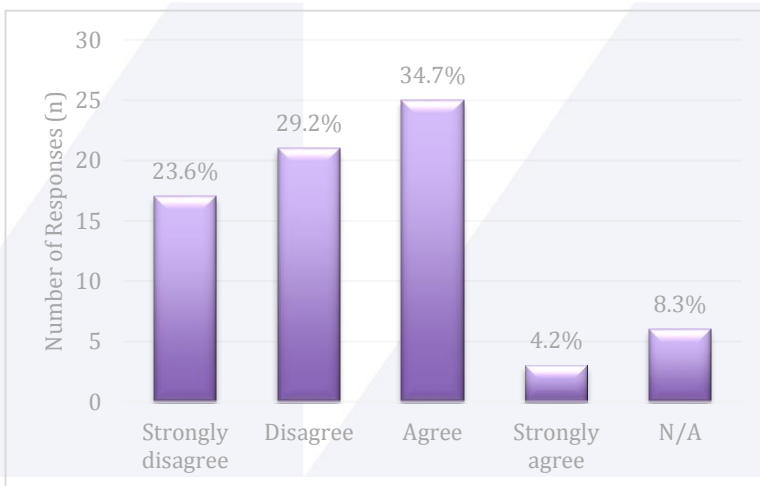
There were between group differences for those who were undergoing general surgical training and other specialty training. The group in general surgical training were more likely to be in agreement that they were satisfied with the overall workload for training (including all assessment and placement requirements) ($p=0.008$).



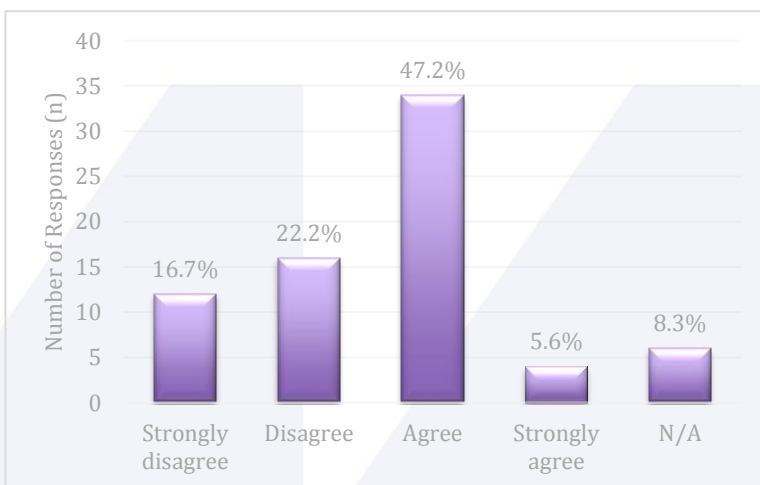
I found that clinical and training activities were well balanced



I found that my clinical workload was manageable



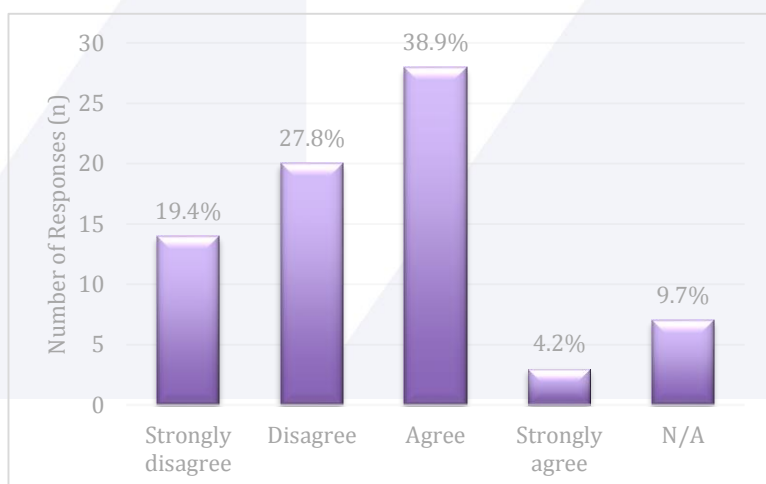
I found that the level of responsibility I was given was appropriate



There were between group differences for those who were undergoing general surgical training and other specialty training. The group in general surgical training were more likely to be in agreement that they were given an appropriate level of responsibility ($p=0.004$).



I found the amount of on-call was appropriate





Qualitative survey responses outlining positive aspects of training

A thematic analysis of sixty-three responses describing the most positive aspect(s) of training was undertaken. The table below outlines the categories used for the thematic analysis as well as sample representative comments from survey respondents to this survey question.

Response Category	Frequency Count (n)	Representative comment/s
Experiences of positive supervision	20	<i>Certain supervisors were supportive and from them I felt connected to the speciality and its community in which I was training. [Survey respondent 1]</i>
		<i>I felt I had an appropriate level of supervision and responsibility and access to teaching and opportunities for research. I was given appropriate opportunities in theatre. [Survey respondent 12]</i>
Working with specific colleagues	20	<i>Some of the surgeons I worked with were absolutely brilliant and inspirational. [Survey respondent 11]</i>
		<i>I worked with some lovely surgeons, nurses and junior doctors. [Survey respondent 63]</i>
Clinical experience and the surgical skills gained	19	<i>I rapidly accumulated operative technical skills that allowed me to become a safe and effective [doctor]. I now use these skills every day in my career. [Survey respondent 42]</i>
		<i>I gained valuable skills and knowledge. [Survey respondent 22]</i>
Training courses and teaching sessions	6	<i>Training days twice a year were useful. [Survey respondent 3]</i>
		<i>I really enjoyed the various hands on training courses run by the college. [Survey respondent 46]</i>
Little or no positive aspects of surgical training	6	<i>Unfortunately very little. [Survey respondent 45]</i>
Availability of information regarding training requirements	3	<i>Clear information on website that we [sic] easy to navigate. [Survey respondent 12]</i>
Patient interactions	2	<i>Patient interactions. [Survey respondent 60]</i>
Other	8	<i>I thoroughly enjoyed my experience, however, I withdrew from the programme because I make [sic] a choice between my young family and my career. If a part-time position (even for just 1 year) had been available [sic] probably would have completed my training. [Survey respondent 24]</i>
		<i>It turned me into a stronger person. [Survey respondent 54]</i>



Qualitative survey responses outlining suggestions to improve training

A thematic analysis of sixty-three responses describing what could have been done to improve training experiences overall was undertaken. The table below outlines the categories used for the thematic analysis as well as sample representative comments from survey respondents to this survey question.

Response Category	Frequency Count (n)	Representative comment/s
Increased support/supervision/teaching access from supervisors and consultants to gain improved operative, surgical and non-surgical experience	17	<p><i>More operative experience as a primary surgeon for major cases - with supervision during day time, able [sic] to perform major emergency operations after hours with more confidence. [Survey respondent 28]</i></p> <p><i>Near total lack of supervision out of hours and often in hours leading to increased stress, lack of personal and/or study time [sic] bad patient outcomes and lack of any kind of system to result in better supervision. [Survey respondent 44]</i></p>
Improvements to the on-call system/safer rostering (reduction in on-call load, increased downtime, part time training)	16	<p><i>Make it easy to train and work part time to allow an easier combination of family and work life. [survey respondent 78]</i></p> <p><i>More support from [sic] parent hospital when having difficulty on rotation. Safer roster. Clear pathway to go for help when struggling or a person/mentor who was not your direct supervisor and had no role in assessment who you could go to. [Survey respondent 12]</i></p>
Provision of safer working environments - removal of sexism, belittling, intimidation, bullying culture	14	<p><i>Less bullying, a process in place to address harassment instead of blaming the trainee for everything. If [sic] my big mistake was I complained, this led immediately to poor feedback and suddenly blaming my ability at work. The environment was toxic at times. I kept quiet and this led to further bullying. However [sic] it came from the highest people in the department. [Survey respondent 76]</i></p> <p><i>Working in a more positive environment with a culture of appreciation, positive as well as constructive feedback and genuine assessments which are aimed to improve and lift performance rather than invoke fear. [Survey respondent 69]</i></p>
Developing a stronger mentoring programme/pathway with independent representatives to provide trainee support	8	<p><i>Developing a strong mentor-mentee programme. I didn't feel there were too many people I could talk to, who would be prepared to support me through the year. [Survey respondent 3]</i></p> <p><i>An independent more involved representative from RACS with whom open discussion [sic] during training. [Survey respondent 1]</i></p>



Response Category	Frequency Count (n)	Representative comment/s
Redesigning the rotational system with improvements to allocating according to trainee preferences	8	<i>Not being sent away to another state low down on my preference list. [Survey respondent 75]</i> <i>Address impact on families caused by changing cities every year. [Survey respondent 64]</i>
Increased transparency in the College and assessment processes	6	<i>More transparency in assessment. [Survey respondent 9]</i>
Training of supervisors on feedback, professionalism, educational theory	5	<i>Honest feed backs [sic] from the last lot of trainers and in general just be a bit HONEST. [Survey respondent 26]</i> <i>If RACS and my supervisors had a greater awareness of relevant educational theory and had actively sought to incorporate these well-established principles I might have had a better training experience. [Survey respondent 62]</i>
Assistance provided at local level with balancing requirements of specific placements with training programme requirements	5	<i>More support for exam leave and on-call commitments. [Survey respondent 53]</i>
Supervisors to be made accountable for performance	4	<i>Improve support, remove abuse, introduce accountability for supervisors. [Survey respondent 22]</i>
Anonymous feedback system coordinated by RACS that trainees can utilize to raise training issues	4	<i>Truly anonymous feedback. [Survey respondent 34]</i> <i>Independent third party person to involve in the training processes which may reduce the chance of trainee to be bites [sic] in the snake pit. [Survey respondent 68]</i>
Improved support provided during probation/remediation	3	<i>When on probation, to be given actual support rather than quadruple my workload with excessive assessments. [Survey respondent 18]</i>
Improved communication from the College regarding training requirements	3	<i>Discussions with female surgeons prior to commencing training; better communication from RACS after sudden job changes. [Survey respondent 32]</i>
Revising the curriculum to match the knowledge and skills required to become a surgeon	2	<i>The curriculum and syllabus do not match the skills and knowledge actually required to be a competent and even [sic] outstanding surgeon. To quote a college councillor at the time "the part 1 exam is a commitment test, not a surgical test". [Survey respondent 17]</i>
Other	13	<i>Removal of thesis requirement during training years 2-4 - I felt this requirement took time and focus off clinical exposure and study during these important years. [Survey respondent 71]</i>



Response Category	Frequency Count (n)	Representative comment/s
		<i>I could have been treated with greater kindness and understanding and allowed to complete my PhD.</i> [Survey respondent 21] <i>I think the term "training" cannot be applied to what I experienced.</i> [Survey respondent 56]
Nothing more to add	8	<i>Already answered previously.</i> [Survey respondent 31]



Qualitative survey responses suggesting improvements to training

A thematic analysis of forty-eight additional comments or recommendations to improve the Surgical Education Training Programme was undertaken. The table below outlines the categories used for the thematic analysis as well as sample representative comments from survey respondents to this survey question. The table is split into recommendations and additional comments.

Response Category for Recommendations:	Frequency Count (n)	Representative comment/s
Equal opportunities to be made available for accessing part-time training, job sharing, flexible training pathways and maternity/paternity leave during training	7	<i>I acknowledge the competing nature of both my career choices at the time and my family life. Regardless [sic] for women within the training [sic], support to take time off and resume appears significantly easier to achieve. I was chastised for seeking one week of parental leave at the time of my son's birth. [Survey respondent 1]</i> <i>Making part-time training a reality, with no discrimination in the workplace if a trainee chooses to have children or work part-time/job share. [Survey respondent 3]</i>
Review and revision of assessment process overall	4	<i>Independence of surgical accreditation from education and training to remove conflict/bias of peers/future peers/work colleagues as assessors. [Survey respondent 9]</i>
Improvement to components of training programme	3	<i>Consider putting first year trainees into smaller, friendlier, more-supported hospitals to develop their confidence and skills in a good environment, rather than in an environment that is designed to weed them out! [Survey respondent 3]</i>
Improvements to training of supervisors	3	<i>You need to put supervisors of training in ace [sic] who actually care about trainee welfare. There should be access for training of these people in how to relate to trainees and their concerns. [Survey respondent 35]</i>
Provision of individualised remediation options for those identified as under-performing	2	<i>When struggling trainees are indentified [sic], more individualised management of deficiencies, rather than just dumping the standard package of extra assessments on them etc. [Survey respondent 6]</i>
Introduction of an independent mentoring system for trainees coordinated by RACS	2	<i>Provide and [sic] independent mentor that has NO relationship whatsoever with any consultant the trainee is working under and give that mentor power to advocate directly with RACS to assist with problems that trainee may be having. The issue of independence and confidentiality is paramount otherwise trainees will NOT report issues because of the absolutely real possibility of retribution. [Survey respondent 46]</i>
Provision of systems for trainees to report bullying, humiliation and sexual harassment	2	<i>Provide clear unbiased pathways for trainees to raise and address bullying. [Survey respondent 17]</i>
Revisions to the on-call system during training	2	<i>Safe working hours needs to be addressed. [Survey respondent 13]</i>
Improved processes for placement allocations	1	<i>Provide some forward planning as to locations where trainees will be placed. [Survey respondent 10]</i>
Provision of individualised support for trainees returning to training	1	<i>Most consultants I have worked with have been truly amazing and supportive and many urged me to continue training and then return to training. I did not get this feeling from the College. It has been a difficult process to get back onto the training program and very disappointing that NONE of my previous Australian training will be accounted</i>



Response Category for Recommendations:	Frequency Count (n)	Representative comment/s
		<i>for. It would be good if someone could look at trainees on a case by case basis, and that we could have more of a voice.</i> [Survey respondent 34]
Revisions to the information provided on the post Fellowship years	1	<i>Provide more post fellowship planning advice.</i> [Survey respondent 10]



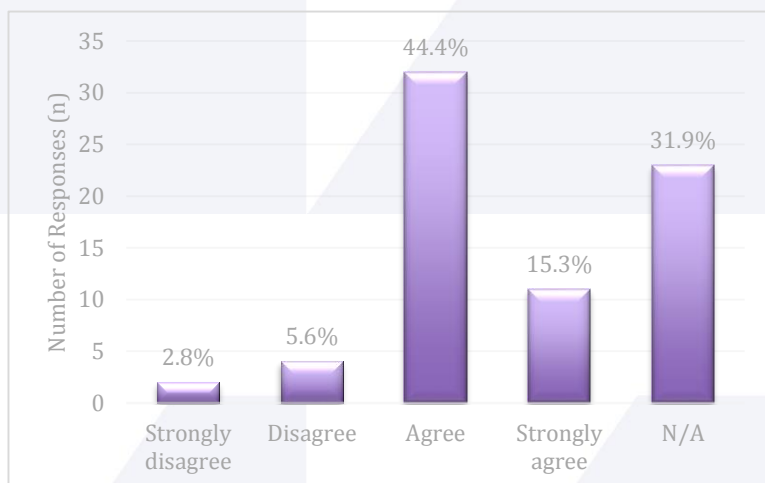
Response Category for Additional Comments	Frequency Count (n)	Representative comment/s
General challenges and negative experiences during surgical training (including reports of suicide, depression, bullying)	10	<i>I just want you to know that surgical training made my life a living hell. I mean that literally. I was depressed and suicidal.</i> [Survey respondent 2] <i>There are two [surgeons] who I believe bullied me out of the profession, and who continue to bully others.</i> [Survey respondent 66]
Lack of transparency of the Board and College processes	7	<i>I was really let down. It was evident that these people were friends and that discussions were being held outside formal meetings.</i> [Survey respondent 29] <i>Lack of transparency, equality, empathy from RACS.</i> [Survey respondent 37]
As above/previously stated comments	6	<i>As above.</i> [Survey respondent 62]
General positive comments regarding surgical training experiences	5	<i>On the whole the formal SET program is very well run and thorough.</i> [Survey respondent 33]
Lack of supervision and support	4	<i>Lack of supervision, debriefing and mentoring.</i> [Survey respondent 44]
General positive comments towards investigating reasons for withdrawal from training	3	<i>This survey is a good idea!</i> [Survey respondent 77]
Experience of unprofessional supervision and/or mentoring	2	<i>I remember the mentor saying surgery is not for women.</i> [Survey respondent 58]
General negative comments towards investigating reasons for withdrawal from training	2	<i>This survey to me feels like a very token gesture from the college, who will never actually change.</i> [Survey respondent 27]
Other comments	6	<i>A lot of the issues come down to the individual rotation or hospital and their roster, workload and consultant personalities which are obviously harder things for the college to address than any systematic issues.</i> [Survey respondent 12]



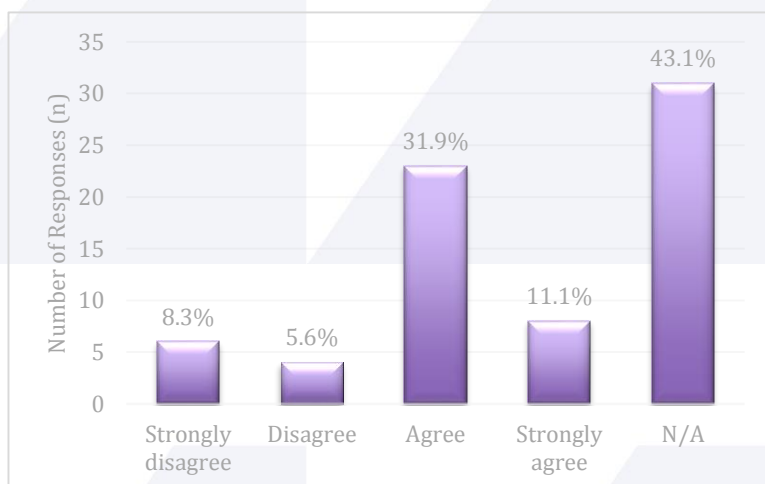
OVERALL ASSESSMENT EXPERIENCES

Survey items related to assessment have been grouped together in the following section. Frequency charts showing the proportion of agreement and disagreement or not applicable responses [N/A] are shown below.

I was satisfied with my experience with the Generic Surgical Sciences Exam (GSSE)

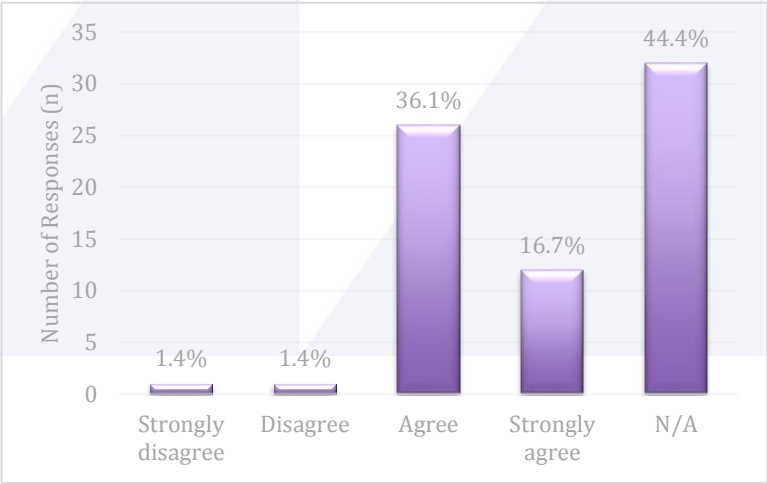


I was satisfied with my experience with the specialty specific Surgical Science Exams

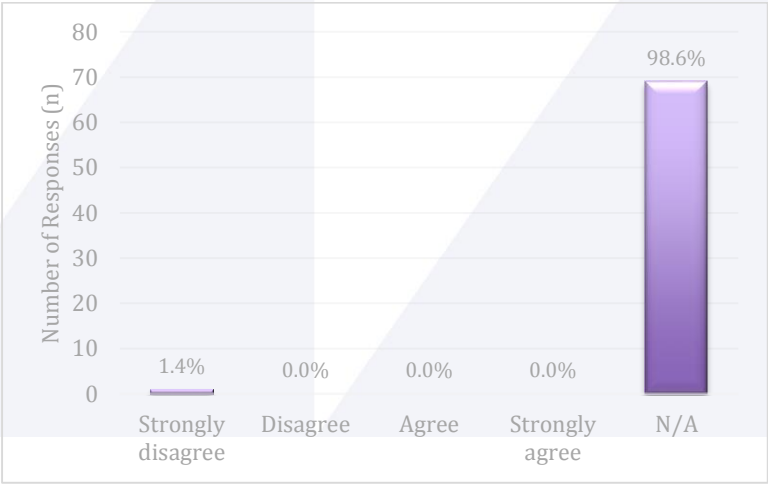




I was satisfied with my experience with the Clinical Exam



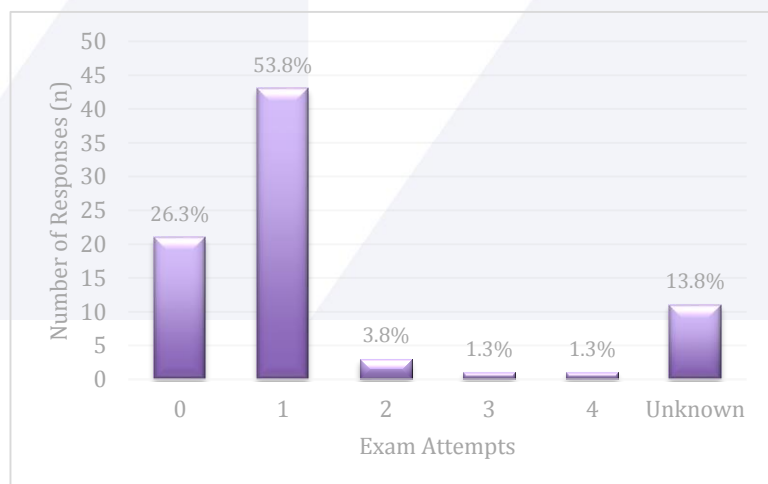
I was satisfied with my experience with the Fellowship Exam





Respondents were asked to report on the number of attempts and the outcome at the examinations in the surgical training programme.

Number of attempts at the Generic Surgical Sciences Exam (GSSE)

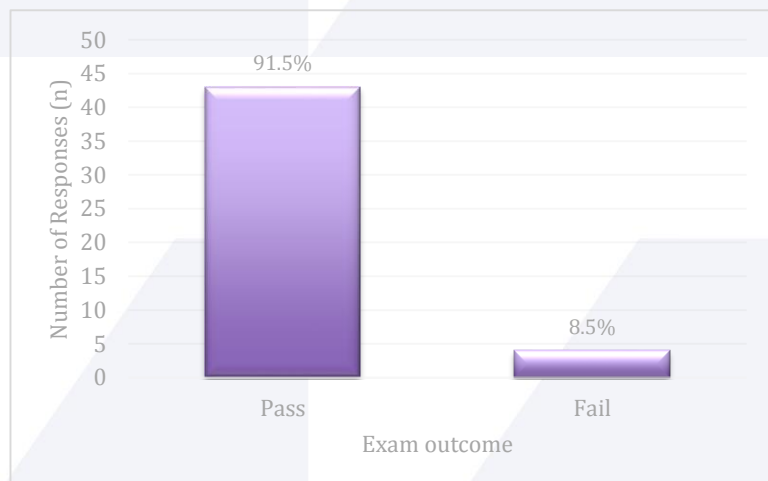


GSSE Attempts

Min	0
Max	4
Mean	0.8
Mode	1
Median	1
SD	0.7

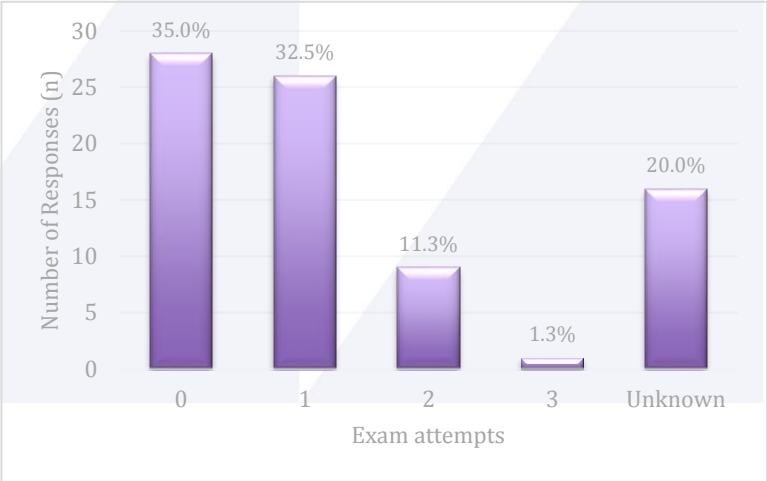
Outcome of the GSSE

Of the forty-seven respondents that attempted the GSSE, their exam outcome is presented in the graph below.





Number of attempts at the Specialty Specific Exam (SSE)

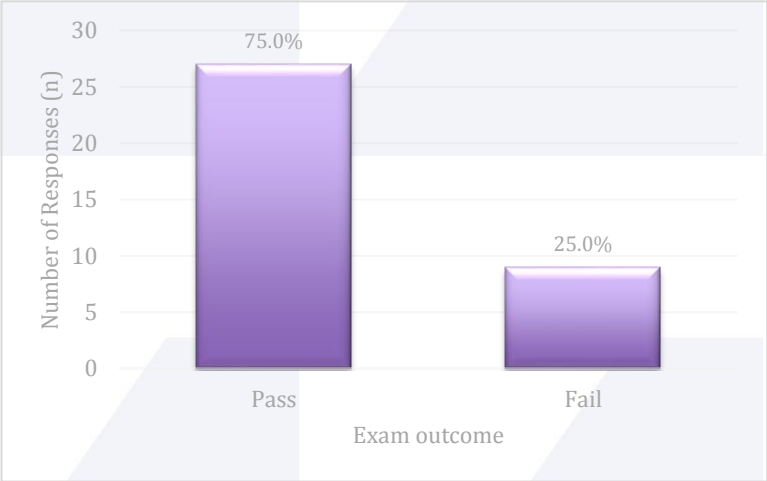


SSE Attempts

Min	0
Max	3
Mean	0.7
Mode	0
Median	1
SD	0.8

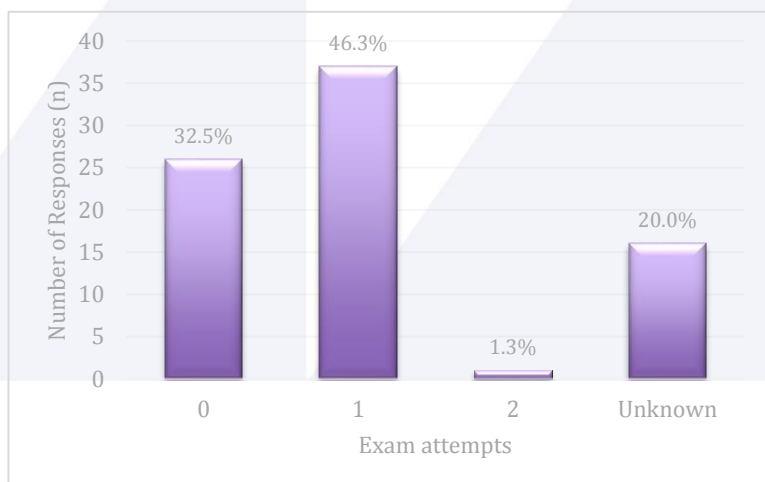
Outcome of the SSE

Of the thirty-six respondents that attempted the SSE, their exam outcome is presented in the graph below.





Number of attempts at the Clinical Exam



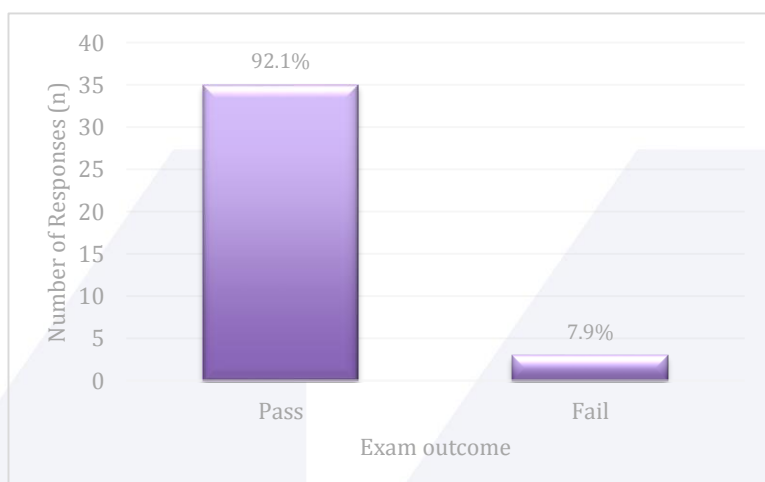
Clinical Exam attempts

Min	0
Max	2
Mean	0.6
Mode	1
Median	1
SD	0.2

There was a difference in the responses to this item between those who took an interruption from training and those who did not. The group who took an interruption from training had attempted the Clinical Exam on significantly more occasions than the group who hadn't interrupted from training ($p=0.022$).

Outcome of the Clinical Exam

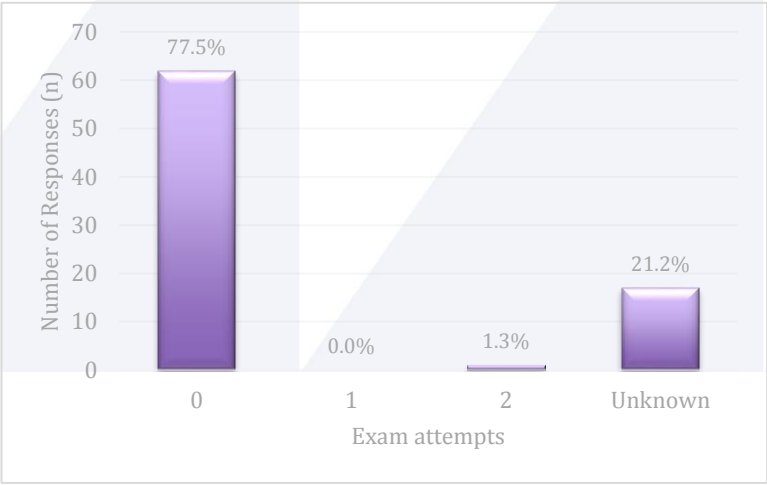
Of the thirty-eight respondents that attempted the clinical exam, their exam outcome is presented in the graph below.



There was a gender difference in the responses to this item. Women were more likely than men to report a successful outcome in the clinical exam ($p=0.025$). All female respondents passed the clinical exam.



Number of attempts at the Fellowship Exam

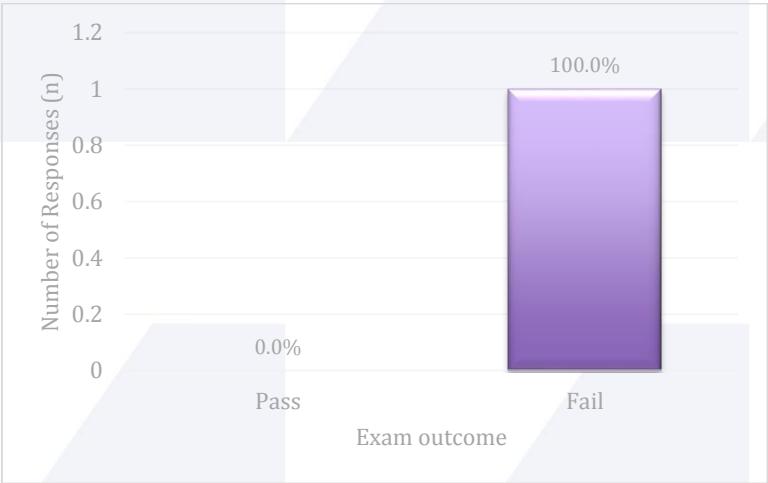


Fellowship Exam attempts

Min	0
Max	2
Mean	0.0
Mode	0.0
Median	0.0
SD	0.3

Outcome of the Fellowship Exam

Of the one respondent that attempted the Fellowship Exam, their exam outcome is presented in the graph below.

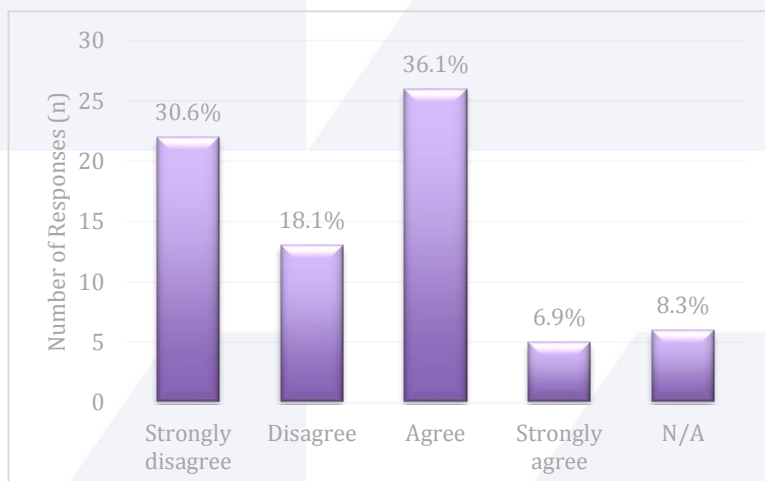




CLINICAL SUPERVISION AND MENTORING

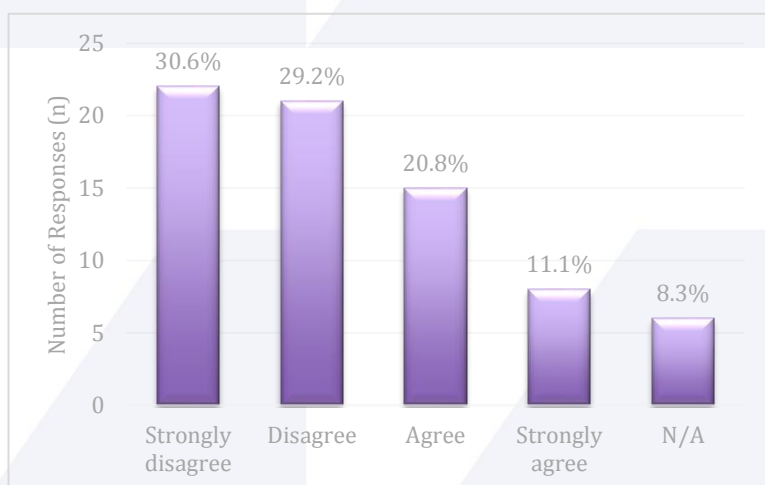
Good clinical supervision and mentoring can be considered critical to successful progress in clinical education. This section evaluated to what extent trainees who had withdrawn had a good experience of these elements of training. Frequency charts showing the proportion of agreement and disagreement or not applicable responses [N/A] are shown below.

I was satisfied with the amount of clinical supervision / support provided



There was a difference between the responses of the two groups of respondents who interrupted from training for less than 12 months or 12 or more. The group who interrupted for 12 months or more reported a higher level of agreement that they were satisfied with the amount of clinical supervision / support provided ($p=0.038$).

I felt supported by my supervisors

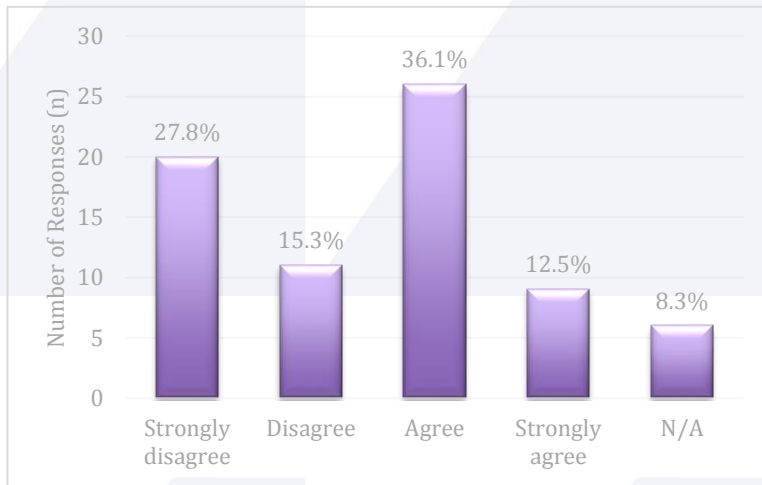


There was a difference between the responses of the two groups of respondents who interrupted from training for less than 12 months or 12 months or more. The group who interrupted for 12 months or more reported a higher level of agreement that they felt supported by their supervisor(s) ($p=0.025$).

There were also between group differences for those who were undergoing general surgical training and other specialty training. The group in general surgical training were more likely to be in agreement that they felt supported by their supervisor(s) ($p=0.024$).

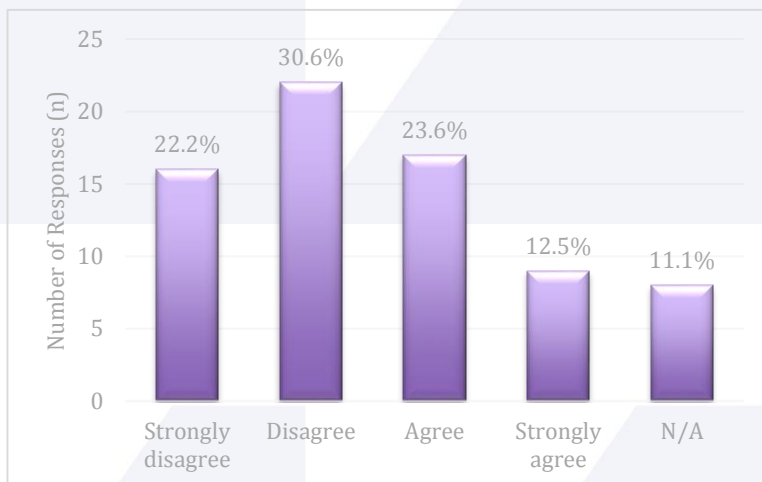


I found my supervisor(s) to be professional



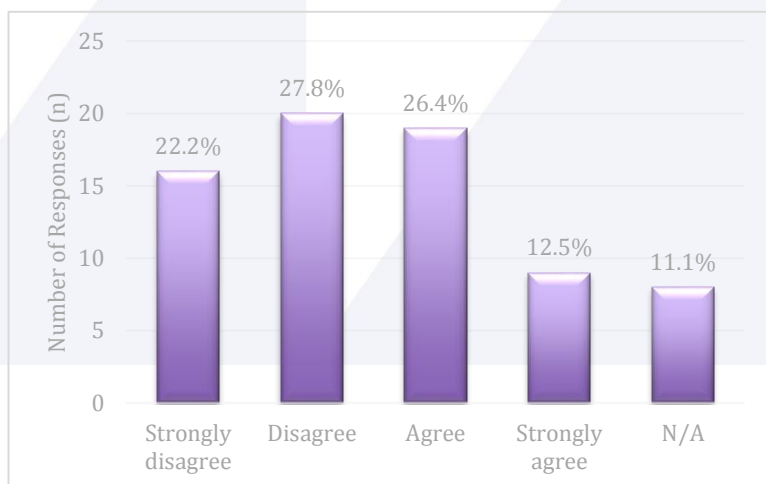
There were between group differences for those who were undergoing general surgical training and other specialty training. The group in general surgical training were more likely to be in agreement that they found their supervisor to be professional ($p=0.008$).

I found the feedback I received from supervisor(s) helpful to plan my learning

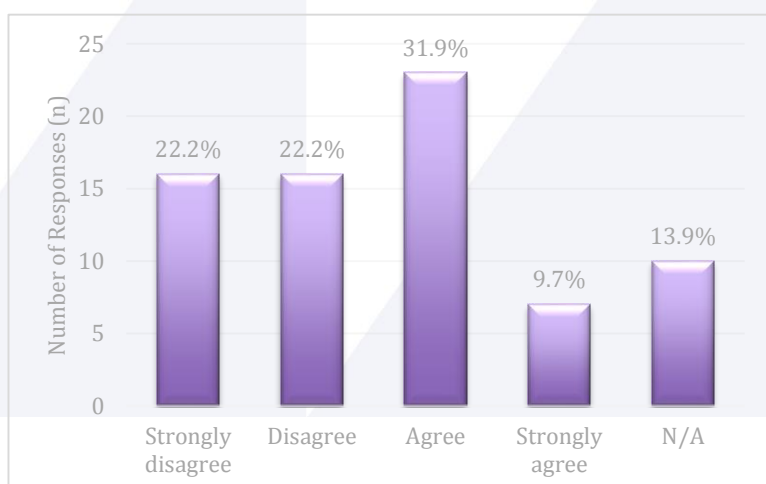




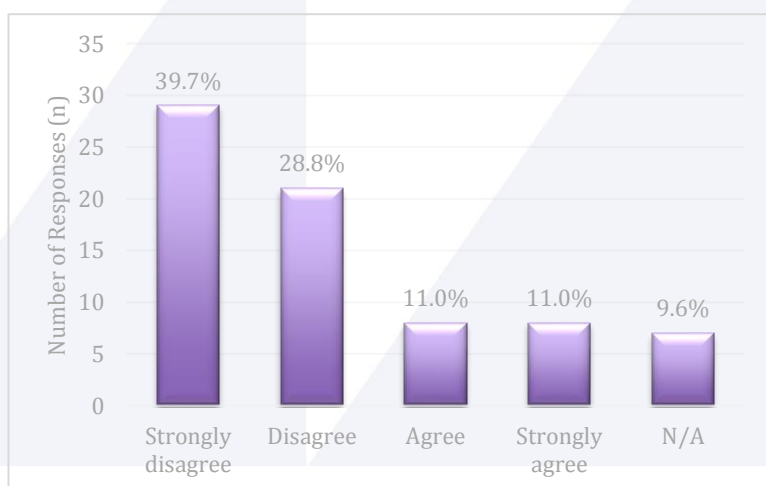
I received timely feedback from supervisor(s)



I received appropriate feedback from colleagues



I was satisfied with the mentoring I received

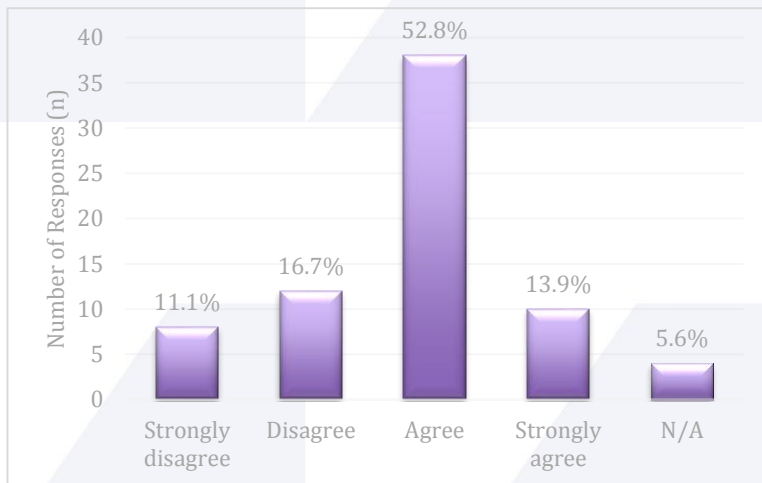




TRAINING PROGRAMME ADMINISTRATION, ORGANISATION AND GOVERNANCE

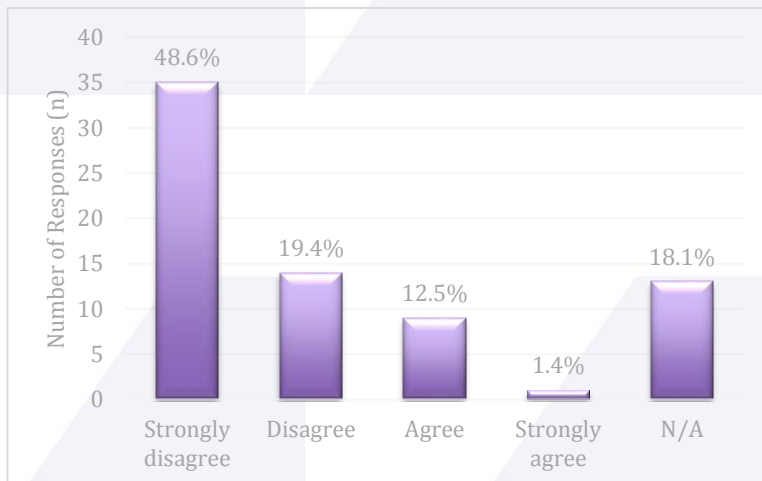
This section evaluated to what extent trainees who had withdrawn were satisfied with training programme processes and administration. Frequency charts showing the proportion of agreement and disagreement or not applicable responses [N/A] are shown below.

I found the information on training requirements was clear



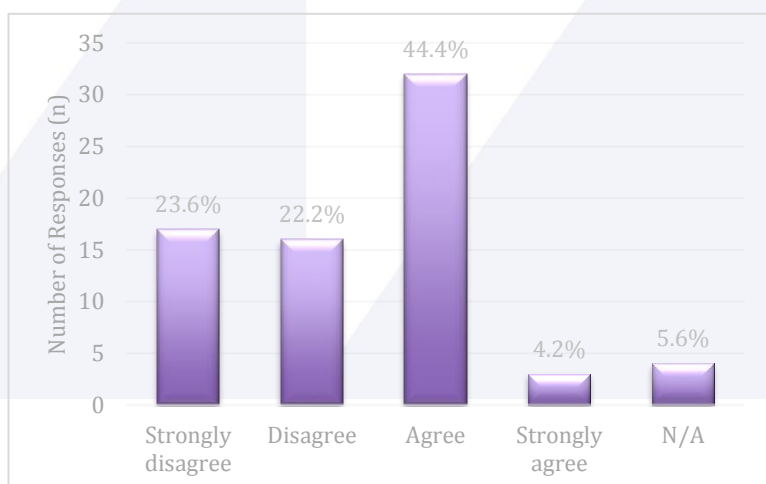
There was a gender difference in the responses to this item. Women were more likely than men to report that they agreed they found the information on training requirements was clear ($p=0.038$).

I found the training programme sufficiently flexible to meet my needs for interruptions to training



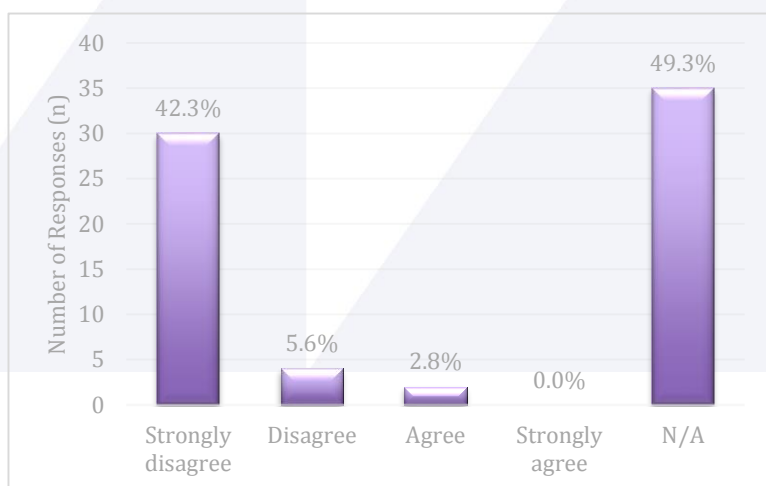


I was satisfied with my access to leave

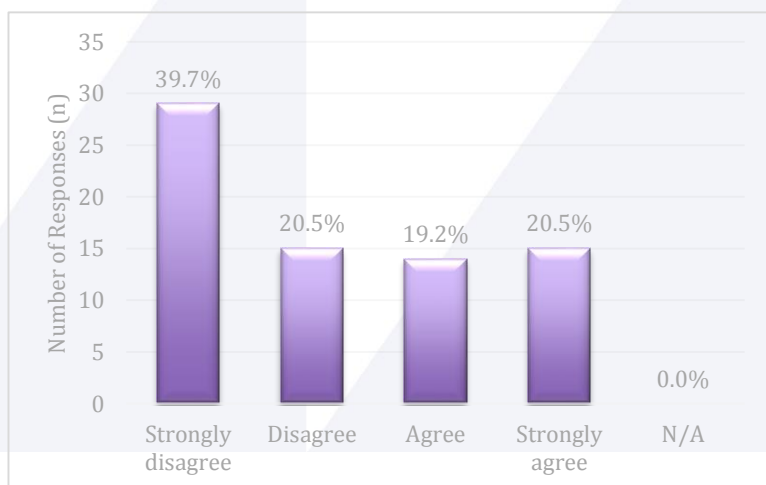


There were between group differences for those who were undergoing general surgical training and other specialty training. The group in general surgical training were more likely to be in agreement that they were satisfied with their access to leave ($p=0.048$).

I was satisfied with my access to part-time training

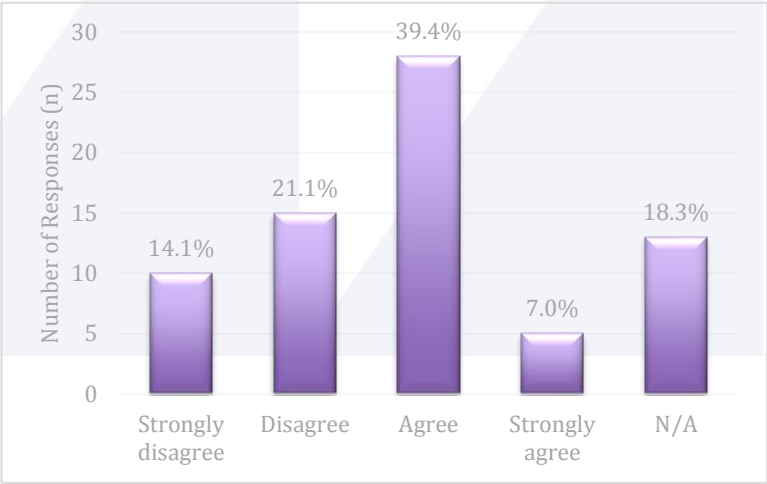


I was unable to gain suitable training experiences

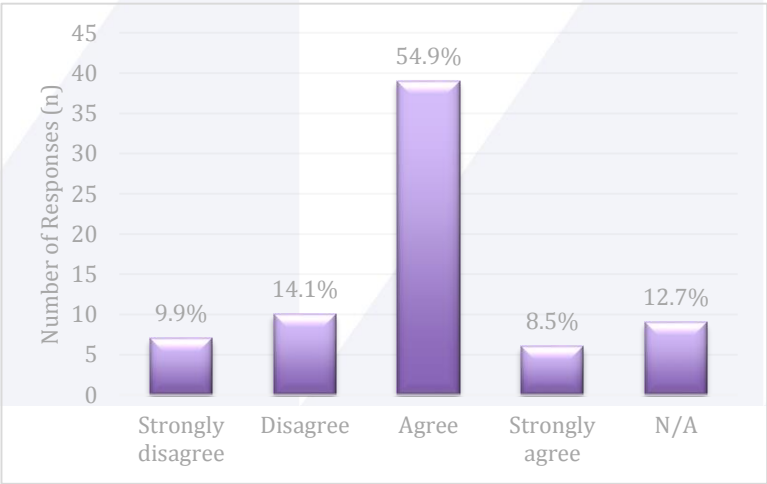




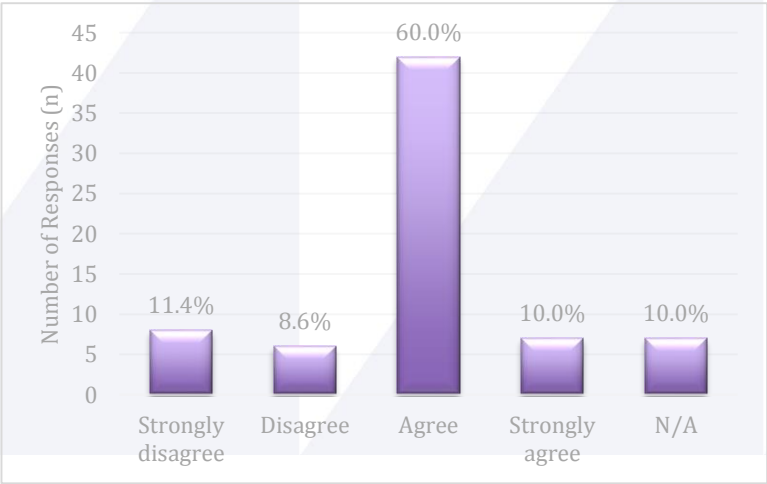
I found RACS staff to be supportive when enquiring about training requirements



I found RACS staff to be helpful, prompt and courteous at all times



I received relevant and timely communication regarding training from RACS







Appendix G:

Interview Participant Demographics

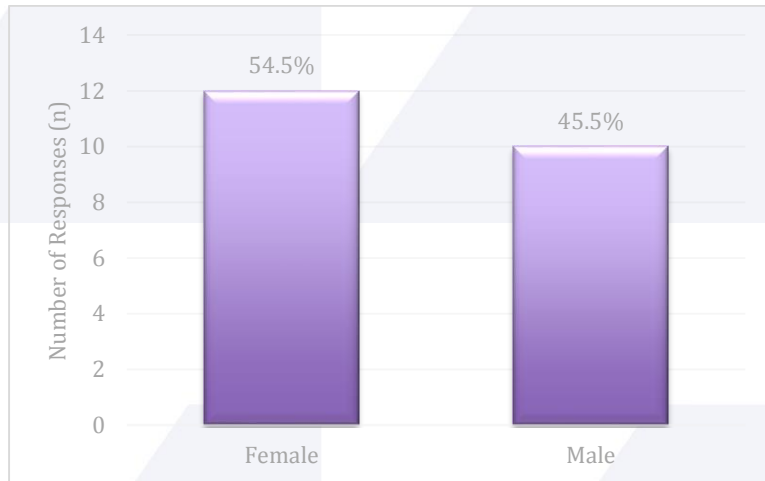




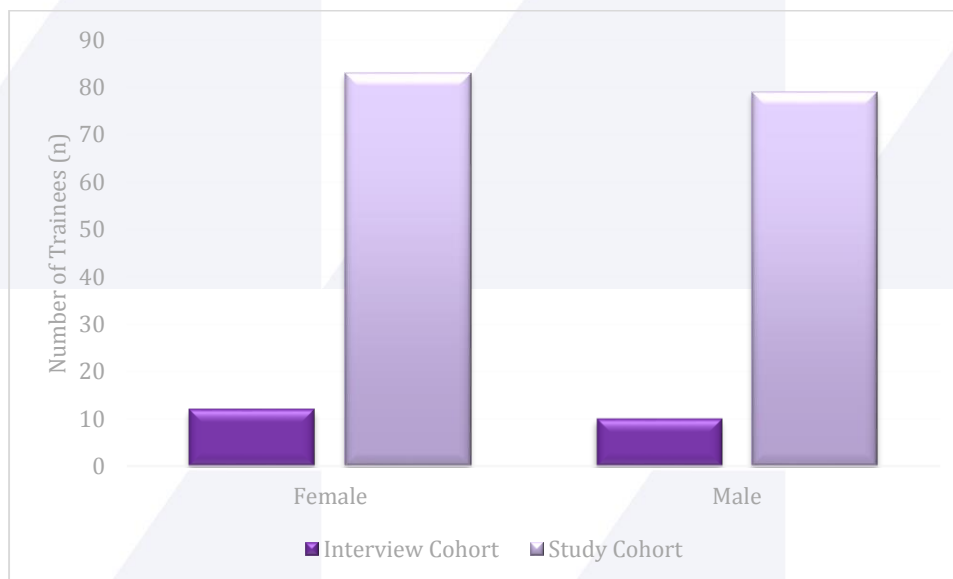
G: INTERVIEW PARTICIPANT DEMOGRAPHICS

Of the eighty survey respondents, twenty-two participated in a follow up interview. This section contains demographic details for the twenty-two trainees that completed an interview.

Gender

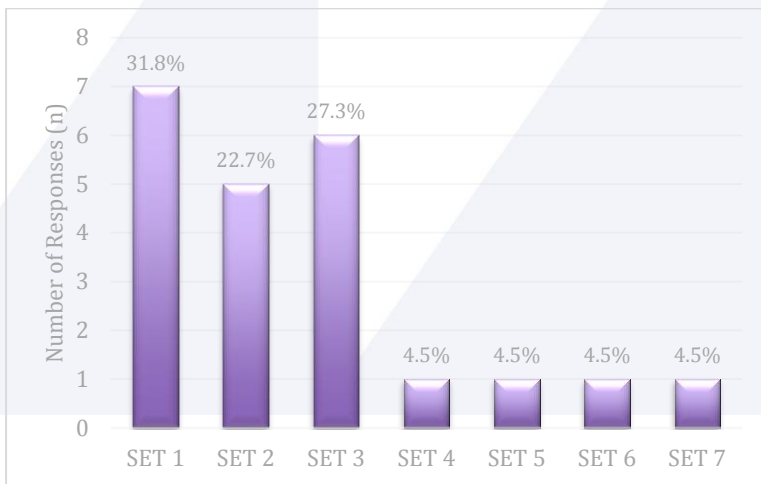


A comparison of the interview response rate with the original study cohort by gender is presented in the graph below.





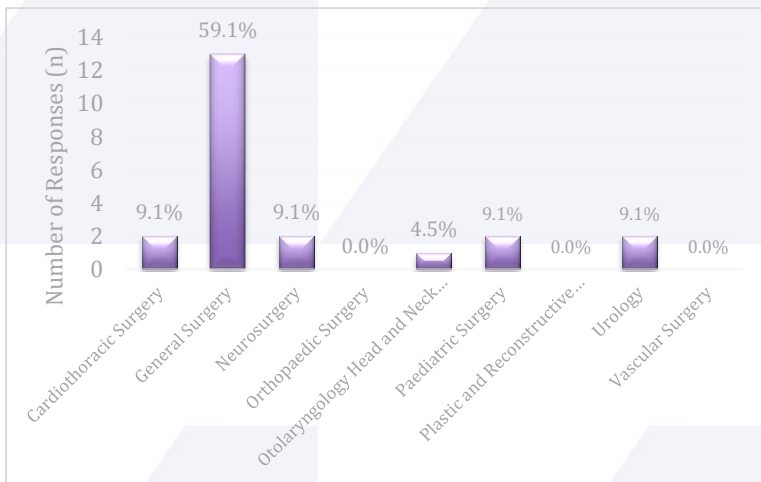
Training level at time of withdrawal



SET Level at time of withdrawal

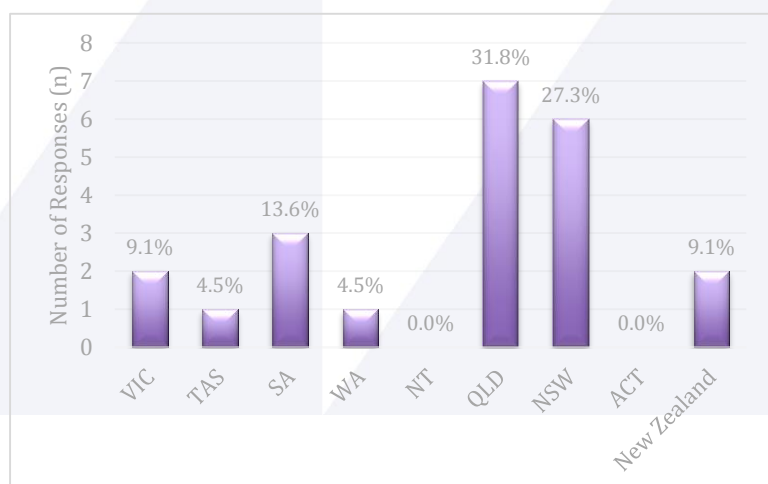
Min SET1
Max SET7
Mean SET2
Mode SET1
Median SET2
SD 1.68

Primary Surgical Specialty





Location at time of withdrawal



Post-surgical training activity

Interview participants were asked to confirm what they have doing since withdrawing from surgical training. The responses were categorised and presented in the table below. Respondents may have provided more than one response.

Response category	Frequency Count = n (%)
Fellow of the Royal Australian College of GPs	5 (22.7%)
General Practice Trainee	1 (4.5%)
Emergency Medicine Trainee	1 (4.5%)
Intensive Care Trainee	4 (18.2%)
Radiology Trainee	2 (9.1%)
Fellow of the Royal Australasian College of Physicians	1 (4.5%)
Royal Australasian College of Physicians Trainee	3 (13.6%)
Completing a PhD	1 (4.5%)
Completing a Masters degree	2 (9.1%)
Surgical Assisting	4 (18.2%)
Medical Educator	1 (4.5%)
Raising a family	2 (9.1%)
Other (e.g. medical advisor)	2 (9.1%)





I was tired of being treated like a kid at school by the college who made me feel like that the purpose of surgical training was to constantly jump through hoops to only be presented with another hoop immediately following. Despite performing well in all mid and end of term assessments, I still felt the college disregarded consultants feedback and set innumerable, ridiculously expensive courses and expected my entire life to evolve around my career which is an unhealthy way to live...Part-time training was not an option (not technically denied, but made impossible to achieve) and I became aware that I couldn't have both a family and be considered a "good" surgeon.

SURVEY RESPONDENT 18

*“That relief upon leaving was
unbelievable. It was like the
sun came out ...”*

INTERVIEW PARTICIPANT 8