SUBMISSION TO

THE AUSTRALIAN COMPETITION AND CONSUMER COMMISSION

REVIEW OF HOSPITALS FOR BASIC SURGICAL TRAINING

AND

HOSPITAL POSTS FOR ADVANCED SURGICAL TRAINING

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INTRODUCTION

The Key Direction Statement of the Royal Australasian College of Surgeons is as follows:

As a fellowship based organisation, the Royal Australasian College of Surgeons strives to ensure the highest standard of safe and comprehensive surgical care to the community through excellence in surgical education, training, professional development and support.

The values of the Royal Australasian College of Surgeons are:

- Service and Professionalism - performing to and upholding the highest standards
- Integrity – upholding professional values
- Respect and Compassion – being sympathetic and empathetic
- Commitment and Diligence – being dedicated, doing one’s best to deliver
- Collaboration and Teamwork – working together to achieve the best outcome.

Both the key direction statement and the values are consistent with the Review Committee’s criteria for accreditation, which are as follows:

- Producing surgeons that are safe and competent
- Ensuring that the criteria are consistent with comparable countries, unless there are specific Australian conditions
- Facilitate training in the widest range of hospitals including, rural, regional and outer metropolitan
- Criteria for accreditation should be objective and appropriate
- Criteria should be reader-friendly
- Criteria should be publicly justified
- Criteria should be hierarchal, where appropriate, and therefore recognised as such.

The Fellows of the Royal Australasian College of Surgeons provide an enormous pro bono contribution of their time and skills to the development of the College programmes and the hospital based training for both Basic and Advanced surgical trainees. The professional commitment of the Fellows is the most fundamental component in surgical training.

The Review Committee will also consider the possibility of accrediting hospitals rather than specific posts for Advanced Surgical Training.

The College currently accredits hospitals for Basic Surgical Training (BST) and hospital posts for Advanced Surgical Training (AST). Hospitals are accredited for Basic Surgical Training because:

- Clinical experience requirements are more general and very flexible
- Potential positions are more numerous than the selected trainees
- The learning environment, range of clinical opportunities and generic competencies are more important than specialty-specific designated competencies which drive Advanced Surgical Training.
The College considers that the accreditation of individual posts for Advanced Surgical Training is vital and that if a hospital were accredited without specific accreditation of its posts, this would diminish the integrity and quality of the training programme. There may be opportunities to streamline the accreditation process to relieve the administrative burden on the hospitals and on the College.

This submission supports the maintenance of individual posts for Advanced Surgical Training.

The submission is divided into 3 sections and covers the following topics:

1. Quality Issues
   1.1 Hospital and Hospital Post Accreditation
   1.2 The needs of the surgical trainee
   1.3 Consultation with trainees
   1.4 Patient needs
   1.5 The Surgical Supervisor
   1.6 Distribution of hospital posts.

2. Educational Issues
   2.1 Impact of Hospital Accreditation on Educational Improvements
   2.2 Hospital Posts Integral to Training Programmes
   2.3 RACS Core Surgical Competencies
   2.4 Assessment review
   2.5 Curriculum Development and Evaluation
   2.6 Training Networks
   2.7 Part-time and interrupted training
   2.8 Private Sector Training Initiative.

3. Administrative Issues
   3.1 Accreditation team visit
   3.2 Annual Report
   3.3 Standard documentation
   3.4 Record keeping
   3.5 Jurisdictional Representatives
   3.6 Appeals Mechanisms.
1. QUALITY ISSUES

The Royal Australasian College of Surgeons is committed to excellence in surgical education.

The Fellows of the College demonstrate such commitment within their own professional practice through adherence to high professional standards and continuing professional development.

The Fellows also demonstrate such commitment to the profession as a whole in their pro bono work which includes:
- involvement in selection of applicants for surgical training positions
- acting as supervisors and mentors to basic and advanced surgical trainees;
- their work accrediting hospitals and hospital posts;
- developing and conducting examinations and other assessments; and
- conducting and supporting mandatory surgical skills training programmes.

The accreditation of hospitals and hospital posts is critical to ensure and support quality of surgical practice within our community now and in the future.

The College provides educational leadership. It is the umbrella educational body for surgical practice and is particularly focussed on developing and promoting strategies and practices which will ensure high quality of surgical care in Australia and New Zealand. The College role in the accreditation of hospitals and hospital posts is therefore a component of clinical governance ensuring that health care safety and quality is monitored, evaluated and continuously improved, particularly so that the surgeons of the future know and adopt the RACS values as the foundations of their professional culture and practice.

1.1 Hospital and Hospital Post Accreditation

The quality framework and requirements for surgical training differ for basic and advanced surgical trainees.

Basic surgical training (BST) is the platform for specialist surgical expertise and skills. The focus for BST accreditation is necessarily broader than for AST with more emphasis on the hospital as a safe and appropriate learning environment where a wide range of generic surgical and other clinical experiences across the surgical competence domains can be gained. BST Regulations describe these requirements including ED and ICU rotations as well as the surgical rotations.

Hospital organisation, policies and procedures must provide a positive learning environment that is demonstrably supported by the hospital administration and the local community of surgeons. This would include hospital and College policies and programmes to deal with bullying and harassment. It also includes resources (human and physical) needed to maintain that environment.
The processes for survey and accreditation of hospitals for BST are currently under revision and outcomes of the deliberations of the Review committee will assist the finalisation of this revision.

Accreditation for Advanced Surgical Training (AST) requires the same set of general standards, attitudes and activities. However, the focus for specialist surgical accreditation is the particular requirements that are necessary to support the acquisition of surgical expertise by individual trainees in a particular specialty.

Variations from hospital to hospital and within individual hospitals mean that it is inappropriate to accredit a hospital for the entire range of advanced specialties. Each hospital has its own profile of type and quality of equipment, staffing levels, unique patient case-mix and working requirements of surgical trainees. Thus, each specialty has identified in its respective inspection documentation, the requirements and conditions for the accreditation of a hospital post to ensure that it provides an effective and acceptable framework for achieving quality educational outcomes for trainee surgeons in that specialty. The specialty inspection teams have the necessary expertise and responsibility to evaluate factors which determine the viability of a post.

The current inspection criteria will be expanded to include a review of hospital standards across a number of domains. The College is committed to a broader perspective than a count of surgical beds, outpatient clinics, operating lists, inpatient separations and number of surgical procedures and facilities. The quality of patient care depends not just on surgeons but also on the policies and resources that hospitals provide to clinical governance, systems reviews, root cause analysis, audit capacity, mentoring by staff (other than the trainer) and support for trainees (in addition to that provided by the Surgical Supervisor). These represent just some of the areas where the College is improving its appraisal when determining the suitability of a post.

This approach to a hospital inspection is aligned with the RACS Core Surgical Competencies, which the College expects of its Fellows (see 2.3) and should ensure that the hospital provides an integrated training programme that is relevant to the trainee and ensures optimal health care for the patient whose care involves the trainee.

Assessment of hospitals against such competency criteria will not be an onerous task as they are applicable across all surgical and medical specialties and are easily identified or demonstrated within a hospital. The College has commenced discussions on the most effective methods for measurement of these principles.

There is a collaborative arrangement between the employing agency (i.e. the health service / authority) and the training agency (i.e. the College). Accreditation requires a clear articulation of the obligations of the health service / authority to provide the infrastructure and ongoing support required for the College to accredit a hospital or post. This is a form of contract between the College and the authority. In short, there are obligations on both parties. Furthermore, accreditation for both BST and AST requires clear articulation of the obligations on the training supervisors and the surgical staff members in the hospitals, as outlined by the RACS training boards.
1.2 The needs of the surgical trainee

Basic surgical trainees and advanced surgical trainees have different educational and work experience needs as the individuals hold different levels of knowledge and expertise in the continuum of surgical practice.

Basic surgical trainees require general training across a broad base. They are being guided to master the basic sciences of surgery and the basic principles of clinical medicine, peri-operative care and the function of surgical systems. It is important that basic surgical trainees are supported by their hospital BST supervisors while they work with and receive training from a variety of surgeons and other clinicians across a number of specialities, learning about a range of surgical care processes and patient interventions. Some clinical rotations particularly assist the learning of basic sciences in the practice setting (e.g. care of trauma patients, patients in ICU and patients presenting to ED). See Appendix 1 for details of these terms.

As the processes for surveying and accreditation are revised and approved, the College is increasing BST training numbers (increasing 2005 intake into BST 1 by 20% to 240).

BST trainees, in particular, should not learn in isolation. They benefit from interaction with peers during this phase of their training. For this reason, care will need to be taken to avert adverse consequences of approving large numbers of new hospitals for BSTs. Nevertheless, the College will be ready to accredit more hospitals for BST as soon as the review of accreditation processes is complete.

Advanced surgical trainees are supported through a series of mentoring and training relationships with Fellows. These Fellows provide them with consistent individualised attention and feedback necessary to acquire the high level of surgical knowledge and technical expertise for the practice of surgery as independent practitioners. This must be in hospital posts that have adequate trainer expertise and availability, and the caseload, case-mix and infrastructure support necessary to develop the standards of surgical competence which are defined by the curricula and assessment processes.

The balance between numbers and range of surgical procedures varies for each specialty. For some specialties, surgical competence has been proven to be linked to the number of procedures performed. In other specialties, clinical care effectiveness requires experience with a wide range of surgical interventions.

Advanced surgical education is particular to a specialty and to a post within a hospital. As such, this cannot be assessed for a hospital as a whole. The learning objectives, caseloads, range of learning opportunities, infrastructure resources, nature of supervision and rigour of performance review processes can vary greatly between clinical teams, departments and hospitals.

Specialty Advanced Surgical Training Boards carefully match individual trainees to individual training posts on a yearly basis, thereby ensuring that each advanced surgical trainee receives both breadth and depth of training.
Accrediting hospitals rather than posts for all specialities might seem to have the potential to increase the number of posts that are available for AST. However, the standard and quality of training would probably fall as a consequence of removing the accountability of hospitals and supervising surgeons for the training and work requirements of trainees. This accountability is demanded by the College on behalf of each individual trainee and the community.

The College wants an increase of posts for advanced surgical trainees. To retain the standards of the training programmes and trainee working conditions, this increase must be matched by adequate infrastructure, funding and support for individual AST posts. Accrediting hospitals (rather than posts) for advanced training, without taking into account the range and number of surgical experiences relevant to each specialty, will further diminish the quality of the training experiences and the outcomes of training. This will lessen the standards of surgical service to the community in the future.

Hospitals are dynamic institutions. Changes occur in specialist staff resources, caseloads, access to outpatient clinics, staffing ratios and elective operating sessions. The effects of such changes will not be uniform. One post will be more adversely affected than another. An individual trainee may be more adversely affected in his / her learning than the whole trainee cohort. Every surgeon must become excellent thus requiring every training post to remain at a high standard.

Advanced Surgical Training allows a trainee to progress from an initial point of continuous supervision to one of assuming increased responsibility for the clinical decisions regarding the peri operative and intraoperative management of patients. This incremental responsibility is carefully, individually and closely monitored by the supervisors of surgical training. The function of the supervisors depends upon the authority of the College which is exercised in the standardised accreditation of AST posts. The surgical workforce shortage, particularly in Regional areas, also means that the availability of appropriate teachers and supervision is variable and needs to be assessed on a post specific basis and at regular intervals.

In hospitals where staffing and resources fall below levels which can sustain the RACS training requirements, accreditation of posts may be withdrawn. In hospitals where such resource or workload limitations already exist, accreditation of new posts may not be granted. Similarly in hospitals where the support of surgeons for training programmes in their disciplines is or falls below the RACS requirements, accreditation may be withheld or withdrawn.

The College is committed to improving its processes for ensuring that trainee working conditions in accredited hospitals and within the structures of accredited posts, reflect the RACS policies on issues such as bullying and harassment and working hours.

1.3 Consultation with trainees

The College is aware of the importance of trainee feedback to the quality of surgical training and is sensitive to issues raised by its trainees. Several Specialty Boards have processes in place to elicit feedback from their trainees. For example, orthopaedic advanced trainees complete six-monthly assessments of each post. The College intends to implement a process whereby all trainees will provide objective feedback on
the training and work experiences provided in the individual training posts and hospitals.

The College is concerned that a change from hospital AST post accreditation would negatively impact on the close and committed relationships that Specialty Societies and Training Boards have with their advanced surgical trainees and would hamper future improvements of the type described above. Such change would degrade the College's knowledge base about the comparative strengths of training posts which allows particular needs of individual trainees to be addressed. It would also weaken the peer review expectations of individual surgeons to ensure that their 'units' (i.e. training posts) are maintaining the required training standard. Further, it would reduce the ability of the College to direct rotational programmes, which recognise diversity of learning experiences, trainee requirements, and opportunities for future regional workforce recruitment by exposure to a diversity of environments during training.

It is the accreditation of 'posts' which enables rural and outer metropolitan rotations for trainees to hospitals which would not be able to be independently accredited for AST. The increased availability of training posts in outer metropolitan and rural areas will help ensure that the facilities and equipment in these areas are comparable with those in established hospitals that have been used as training posts for a long time.

1.4 Patient needs

The paramount concern in surgical training is the welfare and safety of patients both now and in the future. The College is not prepared to accept any changes to the accreditation of hospital AST training posts if such change would compromise the quality of surgical care. The College considers that this quality is currently maintained through the accreditation of AST posts to ensure that they comply with the standards defined by the Specialty Boards.

1.5 The Surgical Supervisor

The large number of Hospital Supervisors of surgical training (speciality-specific for advanced training) are critical to the quality of surgical training. Surgical supervisors undertake their roles in a pro bono capacity and are appointed for periods of three to six years. Supervisor duties differ somewhat for BST and AST trainees. The duties of a Hospital BST Supervisor are as follows:

1. participate in the selection of BST trainees (together with hospital representatives and the Regional BST Supervisors' Subcommittee)
2. advise BST trainees on all aspects of BST including career advice and counselling
3. monitor the progress of all BST trainees
4. liaise with hospital administrators regarding appropriate rostering (to allow attendance at compulsory courses) and clinical rotations of BST trainees
5. arrange for in-training assessment of the BST trainees, by assessment forms which are completed at the end of each term / rotation by the clinical supervisor of the term / rotation
6. analyse the trainees' assessment forms and take action in conjunction with the Regional BST Supervisors' subcommittee to improve training experiences in the particular hospital
7. arrange regular meetings with BST trainees to monitor progress – portfolios, assessment reports, distance learning programme modules, performance in skills courses, problems or difficulties
8. attend the accreditation inspection visits of the hospital
9. be a member of and attend meetings of the Regional BST Supervisors’ subcommittee.

Specialty Hospital Supervisor input is specific to the identified posts within a hospital. A brief summary of the main duties of an AST Supervisor is as follows:

- Advise individual Advanced Surgical Trainees on all aspects of surgical training
- Ensure that Advanced Surgical Trainees are correctly registered
- Monitor Trainee Log Book entries by regular inspection
- Arrange regular meetings with surgeons to discuss programmes and progress of individual trainees
- Provide confidential reports to the Regional Subcommittee of the Specialty Board through which the Board will be able to make recommendations regarding eligibility to sit the Part 2 Examination and regarding completeness and progress of training
- Be a member of the Regional Subcommittee of the Specialty Board
- Be present at the inspection of their Specialty Programme at the hospital by the College
- Participate in the selection of Advanced Surgical Trainees together with hospital representative and the Regional Subcommittee of the Specialty Board Committee
- Complete In-Training evaluation forms for each trainee following each rotation
- Identify trainee deficiencies and provide remedial guidance.

Supervisors of advanced surgical training require explicit knowledge and experience in the respective specialty to provide feedback to trainees about the nature of any deficiencies and to provide advice on what is required to remedy such issues.

When numbers of new hospital posts accredited for Advanced Surgical Training, in one or more specialities are increased, there will need to be a corresponding increase in the numbers of supervisors or expansion of their roles. These additional supervisors will require enhanced resources and support.

1.6 Distribution of Hospital Posts

Hospitals (BST) and hospital posts (AST) are accredited based on criteria related to their suitability as learning and teaching environments. It is acknowledged that the number and distribution of accredited training hospitals (BST) and training posts (AST) may have significant bearing on the distributed surgical workforce of the future. However, this evidence is limited in amount and certainty.

BST selection is competitive and entry numbers have been restricted. The Board of Basic Surgical training has now implemented an annual process for determining the distribution of BST trainees between training regions (Australian states and territories)
which is directed towards addressing community need, hospital staffing needs and resources available for training.

An increase of 2004 AST Year 1 numbers to 219 and the resolution of transitional training issues has meant that there can be a corresponding increase in BST numbers for 2005. BST intake will therefore increase by 20% to 240.

Given the RACS approved hospitals and the allocation (by the Board of BST) of trainees to particular training regions, appointment to positions an approved hospitals are, to a significant extent, the choice of the selected BST trainees. BST trainees will choose to go where the learning opportunities, supervision, support and the track record for entry into AST are greatest. Jurisdictions have a role in ensuring that trainees are attracted to those locations where future opportunities will be emerging.

Once selected BST trainees have been allocated to training regions, there are two ways in which the RACS approved hospitals or the health jurisdictions can influence the exposure of BST trainees to different work environments. The first is for the RACS hospital supervisors of BST, the hospital administrators and the jurisdictional representatives to meet to determine the distribution of the allocated BST trainees among the approved hospitals. The second opportunity is at the individual hospital level where the hospital administrators and the RACS hospital supervisors of BST can agree to outer metropolitan and rural clinical rotations. Such rotations are allowed for within the BST regulations and some limitations apply.

The College acknowledges and supports the large contribution of its trainees to the surgical work that is performed in hospitals. The College is committed to establishing and accrediting learning opportunities and posts in locations, which may facilitate future optimal workforce distribution, so long as the standard of training of individual future surgeons is not compromised. The College has been involved in creating new posts in outer metropolitan and rural areas for a number of years and will continue to do so.
2. EDUCATION ISSUES

The College is firmly committed to continued enhancement of the standards of surgical education and training and is focussed on improving the definition and acquisition of surgical competence. Accreditation of hospitals and hospital posts should eventually be determined at least in part, by objective assessment of their performance in ensuring the production of competent surgeons.

2.1 Impact of Hospital Accreditation on Educational Improvement

The College is concerned that an increase in the number of trainees which occurred as a consequence of the accreditation of hospitals (without commensurate funding and infrastructure increases) would interrupt and retard progress with a number of recent developments designed to enrich the quality of surgical training for the benefit of our community.

These include developing explicit definitions about the levels and range of competencies required for different cohorts of surgical trainees in Advanced Surgical Training. The College is working with a number of Federal Government departments and working groups to clarify a common view of the goals of surgical training and the needs of particular groups of surgical trainees and specialists.

Current initiatives include:

- A Medical Specialist Training Taskforce which is researching the educational needs, training requirements and learning environments for medical specialist training
- Research into the special professional needs of overseas trained doctors, in particular those filling designated Area of Need surgical positions
- Research into the special professional needs of rural surgical specialists.

2.2 Hospital AST posts integral to training programmes

Hospital AST posts are part of a clearly defined training programme designed to provide advanced surgical trainees with sufficient caseload, case mix and individualised training and supervision (cognitive and psychomotor). Specialties require trainees to be exposed to a certain number and range of surgical procedures (elective and acute) prior to completing the training programmes, including a mix between trainees as operators and trainees as assistants. These thresholds and case-mix standards are consensus-derived in the absence of objective studies relating to the development of competence. This is monitored through hospital in-training assessments and trainee logbooks. It is important to ensure that these thresholds are maintained in order for the College to continue to oversee the production of competent and safe surgeons. Assessments by mentors/teachers/supervisors are major elements of ensuring adequate trainee progress towards competence.

Currently the Specialty Boards monitor the caseload and case-mix in posts and, if any shortfall in the nature of the surgical experience and supervision in a given post is apparent, then that trainee will be offered another post where this can be rectified. Such monitoring of aggregated hospital data rather than specific information about a
post would be much more difficult and may result in an increased length of training. Furthermore, uniformity of the standards of monitoring and responding would be lost due to delayed identification of a need for remedial training.

The College recognises that even in large metropolitan hospitals some posts may not be able to provide the full breadth and depth of surgical experience required for a particular specialty. The specialty boards monitor their training programmes to ensure that the range of posts, through which a trainee rotates, provides sufficient exposure to the necessary breadth and number of surgical procedures under expert supervision. These posts are located in metropolitan, regional, interstate and Australasian hospitals. The smaller specialties, in particular, require their trainees to take up posts across Australia and New Zealand.

2.3 RACS Core Surgical Competencies

The surgical training programmes of the College are directed towards the graduation of surgeons who are both surgical experts and well-rounded professionals. Surgeons need to demonstrate competency across the domains of:

- Medical Expertise - Clinical Decision Maker
- Technical Expertise
- Communication
- Collaboration
- Management
- Health Advocacy
- Scholarship and Teaching
- Professionalism.

These domains capture the underlying principles of CanMEDS which have been developed into the College’s Core Surgical Competencies. These principles are currently being incorporated into the hospital and hospital post accreditation process, and other aspects of surgical training, education and continuing professional development.

The adaptation of these competencies requirements into the training programme is a collaborative effort between hospitals and the College. The training environment for future surgeons is not restricted to the ward, outpatient clinic or operating theatre. The hospitals, as well as the College, must be aware of their obligations in the development of trainees into professional and accomplished surgeons.

Hospitals with training posts must be able to demonstrate that they have staff with the expertise and skills to facilitate the incorporation of these competencies into the clinical training opportunities. This commitment must be evident at the highest levels of the hospital hierarchies and embodied in the hospital culture particularly in the surgical divisions, departments and teams.

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1 Refer: Davidson, P.M. *The Surgeon For The Future and Implications for Training* ANZ Journal of Surgery 2002; 72: 822-828
For advanced surgical trainees, medical and technical expertise is post specific. The hospital-wide commitment to the incorporation of the other competency goals must be expressed overtly at the level of the individual specialty training post.

2.4 Assessment review

A review of trainee assessment processes is currently underway, which acknowledges and reflects the RACS commitment to quality education and to the need for robust assessment in all specialties.

2.5 Curriculum development and evaluation

Curriculum development in BST has recently focussed on the development of twenty five on-line case studies to help BST trainees to learn the basic sciences. These training modules are practical expressions of the underlying syllabus. Over one million hits per month are received to BST on-line. Multi-choice questions, which are used in BST assessment, are continually reviewed in relation to the responses received through BST on-line.

The College criteria for the development of its curriculum are in close alignment with the criteria that it strives to achieve in accreditation; i.e. objective and appropriate, reader-friendly, publicly justified and hierarchal in presentation.

The fundamental knowledge, skills and attitude objectives for BST are described in a several sources. These include:

- Overall objectives for BST training
- The distance learning programme and the three defined skills courses
- The “Clinical Examination Learning Guide”
- In-house evaluation reports completed at the end of each rotation
- BST and AST selection processes
- Documents supporting survey and accreditation of hospitals

These elements will be bought together in a coherent document that explicitly describes all the criteria as they relate to hospital accreditation for BST. This information will be provided to hospitals in preparation for the survey and accreditation process. The same undertaking is made with respect to AST.

The Advanced Surgical Training curriculum, like its accreditation criteria, is based on the RACS Core Surgical Competencies. The College recognises the importance of evaluating programmes and their respective components. The College is applying the same principles to curriculum and to accreditation. The process of accrediting AST posts constitutes a part of programme evaluation.

2.6 Training networks

The possibility of accrediting training networks across a range of approved posts within a specified region and not necessarily in a hospital setting, would provide increased flexibility and potentially an enhanced training experience for trainees. The College wishes to become more active with respect to these opportunities.
A training network must have clearly articulated and equitable working conditions across all accredited posts and would need to be able to provide backfilling placements to ensure that the network chain is not broken (e.g. through the absence of a trainee on leave). When a post is established in a non teaching hospital setting, such as a private hospital or a rural clinic, it would be imperative to ensure that these placements are approved as part of the accredited training programme.

There would be a variety of benefits arising from such placements. They would expose trainees to an increased diversity of experiences, including pre and post-operative care of patients in different environments and geographic locations. The diminishing number of outpatient clinics in the large metropolitan hospitals is a concern for the College as this limits the trainee experience of ambulatory patient care, which has become such an integral feature of contemporary surgical practice.

2.7 Part time and Interrupted Training

The College has a policy on part time and interrupted training, which is sometimes taken up by trainees. The College is supportive of the accreditation of AST posts that are deemed ‘less than full time’. These posts could be constructed, according to the hospital requirements, as reduced number of hours per day or a specific number of days a week. These posts could be incorporated in the training networks and would suit both male and female trainees who are seeking part-time training and may help to alleviate stresses, which might arise from parental responsibilities, study or other requirements.

The feasibility of these posts will be increased by the development of competency-based learning. Partnership with jurisdictions is critical for the success of such initiatives to ensure adequate employment conditions as well as suitable training.

2.8 Private Sector Training Initiatives

During 2004-5, in collaboration with the Federal Government, the College will pilot a program called the ‘Outer Metropolitan Specialist Training Programme’. The objective of this programme is to provide advanced surgical trainees with the opportunity to undertake training in the private sector, thereby increasing the exposure of trainees to a broader range of surgical conditions and procedures than currently exists in the public hospital sector.

The same criteria should be used to assess the suitability of a specialist training post whether it is in a public or private hospital.

The College will work to support the accreditation of such posts.
3. ADMINISTRATIVE ISSUES

The RACS understands the complexities created in hospitals by dealing with multiple inspection visits from multiple specialties, Training Boards, Medical Colleges and other bodies such as the AMC. It is acknowledged that the current system for accrediting a hospital post is human resource intensive and sometimes inefficient. The process is costly for the inspection team which, to ensure objectivity and standardisation, will usually include membership from a geographical area some distance from the hospital. The RACS wants to work with the key stakeholders to simplify and improve this process.

3.1 Accreditation team visit.

Amalgamating the Basic and Advanced Surgical Training accreditation visits and incorporating several advanced specialties within that amalgamation would streamline the accreditation process. There would still be a need to assess the specialty-specific requirements within a hospital. It may be possible, however, to use a standard assessment of the basic training infrastructure within a hospital or hospital post. Specialty-specific accreditation modules would be added as appropriate.

Currently hospital posts for AST are accredited for up to five years or a lesser period if they are new posts or if there are any deficiencies that need to be rectified. Hospitals are accredited for BST and a three-year cycle is currently preferred.

The College will consider several options (e.g. a possible amalgamation of specialties in fewer accreditation visits, aligning with the common requirements of the Post Graduate Medical Councils in their accreditation processes). The Postgraduate Medical Council experiences may also provide some insights into other options for improvement.

3.2 Ongoing data collection

It has been suggested that regular data collection (some annually) about hospital posts from standard hospital records may offer opportunities for further improvements. This should not create a significant administrative burden but would provide a means of monitoring the continued suitability of posts and provide an ‘early warning’ of problems. This would be supplemented with a corresponding report from the incumbent trainee/s who would also comment on the integrity of the post. It would be important to emphasise to the trainees that their reports would be treated in the strictest confidence.

3.3 Standardisation options

There are several possibilities for increased standardisation to further reduce the administrative burden on hospitals.

A partially standardised form would be possible with some generic criteria for assessment for accreditation. Such proforma would need to include specific sections with accreditation criteria for particular specialties. The structure of the subsequent
Standardised cycles for periods of accreditation would also reduce possible confusion and debate amongst the inspection teams. The College can move towards achieving this.

Electronic submission of accreditation forms will also be considered.

3.4 Record Keeping

The new College information management system will improve the accessibility of data on the accreditation status of each hospital (BST) and hospital post (AST) and enable ready reporting of numbers of posts by specialty, region and accreditation period. This will assist the College in identifying peak demands on resources for hospital inspections and increase the opportunities to streamline the inspection process.

3.5 Jurisdictional representatives

The inclusion of jurisdictional representatives on hospital accreditation visits is a welcome requirement of the ACCC and this has already commenced. The College has developed guidelines to assist jurisdictional representatives and Fellows on the accreditation visit teams to ‘add value’ to the process. As this initiative creates an additional administrative burden, it emphasises the importance of considering the scope for administrative streamlining, mentioned above, to ensure that the accreditation process is affordable and manageable.

3.6 Appeals Mechanisms

The College appeals mechanisms are available in relation to accreditation.

Any decision made by a College committee may be subject to appeal. The committees involved in accreditation of hospitals (BST) and hospital posts (AST) include the Board of Basic Surgical Training, the Board of Advanced Surgical Training and the Education Policy Board. The initial approach should be to the Board of Basic Surgical Training for issues about the non-accreditation of a hospital and to the Board of Advanced Surgical Training, for issues about the non-accreditation of a hospital AST post. Appellants can be any person or entity affected by a decision of the College e.g. applicant, trainee, Fellow, Overseas Trained Doctor, a hospital or a health jurisdiction.

The Appeals Committee expects all other avenues of enquiry to be exhausted before it considers a matter. The Appeals Committee has the right to request any information from within the College organisation (e.g. concerning selection, training and assessment, accreditation) relating to the decisions relevant to the appeal.

The appeals process and the conduct of Appeals Committee Meetings are comprehensively explained on the College website. The site includes detailed guidelines about the conduct of Appeals Committee Meetings, including review of information, interview and representation of the appellant.

CONCLUSION

The Royal Australasian College of Surgeons has demonstrated its commitment to quality in surgical practice and education for close to eighty years. The College commitment to and expertise in surgical education and training are acknowledged by the accreditation received from the AMC in 2001 and by International surgical Colleges. Fellows continue to contribute their time, energy and expertise voluntarily in pursuit of the ideals of excellence in surgical practice and training and will continue to do so in good faith for the benefit of the whole community.

Such professionalism and expertise has resulted in the high standard of surgical practice that is currently experienced by Australasian patients within a health system which, despite its limitations, is envied worldwide.

The College enthusiastically supports improvement in its educational and professional practices and readily accepts its leadership role in clinical governance in promoting quality in the health care services. With that in mind, the College would be pleased to further the suggestions for improvement as outlined in Section 3 and others that arise out of this review process. Equally, the College will ensure that any changes to educational and professional practice are in alignment with its key direction statement and values and actually result in quality outcomes for the community as a whole.

In the opinion of the College, the accreditation of hospitals for BST and hospital posts for AST is the necessary basis for quality surgical education and training. The public benefits of the current processes include high standards of surgical training and practice, pro bono support of the College Fellows and support to trainees through the assured standards of accredited posts and hospitals. Furthermore these trainees, under supervision, provide a large amount of the work of caring for surgical patients in our hospitals, while the College plays its important role in ensuring the quality of their performance. This partnership is of extremely high value to our communities throughout Australia.
Appendix 1

Amendments to BST Regulations
Approved Board of Basic Surgical Training, March 2004

**Emergency Medicine Term:**

That the Emergency Medicine term be a minimum of 10 weeks and that any variation on this was at the discretion of the hospital and state/regional supervisors. Trainees are encouraged to undertake the term in a single run of ten weeks but where unable, can undertake a maximum of three rotations with the minimum per rotation to be four weeks. The required In-Training Assessment Report will apply to the total time.

**Surgical Night Duty Term:**

That night duty in surgical terms be approved at the discretion of the hospital and state/regional supervisors and that trainees may undertake a maximum of eight weeks of night duty during the required 52 weeks of surgical rotations. The hospital BST Supervisor will ensure adequate supervision of training during periods of night duty. The required In Training Assessment Report will apply to the total term in which the period of night duty occurs.

**Relief Term:**

That relief terms in surgery be approved and assessed at the discretion of the hospital and state/regional supervisors. Trainees can undertake up to 12 weeks of relief rotations during the required 52 weeks of surgical rotations. The hospital BST supervisor will ensure adequate supervision of training during periods of relief duty. The required In Training Assessment Report will apply to the total term in which the period of relief surgery duty occurs.

**Country (rural)/Urban Hospital Surgical Term:**

With respect to rotation of basic surgical trainees outside of hospitals approved for Basic Surgical Training, that surgical terms/rotations in country (rural) and urban hospitals (maximum total duration 12 weeks) be approved at the discretion of the hospital and state/regional supervisors and that trainees can undertake a maximum of three such rotations with the minimum per rotation to be four weeks. The required In-Training Assessment Report will apply to the total term in which these terms/rotation occurs.