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EXECUTIVE SUMMARY

In 2001, the Australian Medical Council (AMC) assessed the education and training programs of the Royal Australasian College of Surgeons (RACS). RACS was one of two colleges that participated in the AMC’s pilot of the specialist education accreditation program. This assessment resulted in a decision to grant accreditation to the College for the maximum period, six years, subject to annual reports addressing recommendations made by the AMC Accreditation Team.

In its 2006 annual report to the AMC, RACS outlined plans for a new Surgical Education and Training (SET) program to be phased in from 2008. The existing two-tiered structure, comprising a minimum two-year period of basic surgical training (BST) followed by specialist surgical training (SST) in one of the nine recognised surgical specialties, would be replaced by an integrated program in which trainees would be streamed into a chosen surgical specialty upon acceptance into the College’s program.

The AMC decided SET was a major change to the accredited education and training program of RACS, and therefore would require a review by an AMC Accreditation Team before its introduction.

An AMC Team completed a review of the College’s plans in July 2007. The Team thanks the College President Dr Andrew Sutherland, and College fellows and staff for their detailed preparation and for the generous hospitality extended to the Team.

This Executive Summary provides a short summary of the main findings. It also lists the commendations and recommendations which have been made in the body of the report.

The Team found several quite major changes were planned in surgical training including:

- The major initial changes were the abolition of the basic surgical training stage and a new admission process directly into one of the nine surgical training streams.
- Reducing duration of training.
- Progressive enhancement of curricula and identification of surgical competencies.
- Enhanced in-training assessment with new assessment tools to allow improved formative and summative assessment.
- Moving in time to a competency-based training program and partial phasing out of entirely time-based training.
- Devolution of increased responsibilities to the specialist societies, within well defined Memoranda of Understanding and service agreements.

Introduction of SET has been a complex task. The multiplicity of aims has presented a series of major challenges. Clearly SET is a work in progress and the AMC Team visited at a time when there continued to be significant uncertainties.

Because the outcomes of the selection process were not known at the time of the Team’s review, the Team ask RACS to produce an urgent report to AMC and jurisdictions on completion of selection to SET in 2007, identifying numbers selected by region and specialty to allow any downstream impact on the surgeon workforce to be evaluated. The Team recommended that if there were a potential impact, the College should undertake a second round of selection. RACS provided the AMC with a copy of the report it had made to the Health Workforce Principal Committee on the selection process on 12 October 2007. The Team considered this report to be satisfactory.

The College has emphasised that the next few years will be a period of transition in selection and in the introduction of new assessment methods. The transition process is complex and was not well
understood by employing authorities or by a significant proportion of fellows, despite the College’s considerable efforts to communicate.

In preparation for the introduction of SET, senior College staff have expended considerable effort on communicating about the changes. Nevertheless, the Team had no doubts that, despite this, there was a significant lack of understanding at hospital level about the SET program and its potential effects on hospital staffing. This had led to anxiety and antagonism in many hospitals and several jurisdictions. The Team believed that this was a significant threat to effective implementation of the SET program. The Team considered that an effective communication strategy must be implemented as a matter of urgency.

The Team found that a large majority of supervisors was broadly aware of the SET program. There were large variations in understanding of the effects of changes in surgical training and assessment on supervisory workloads. This has led to major differences of opinion about effects on workloads ranging from increases of several hours a week to no change at all. These uncertainties have been communicated to hospital administrators and jurisdictions and have led to major concerns about effects on the consultant surgical workforce.

The College has recently facilitated and resourced the formation of an internal trainee representative structure, the RACS Trainee Association (RACSTA). RACSTA has been a significant and positive initiative for trainee engagement within the College, and with further expansion of regional networks, there is great potential for the development of stronger communication networks.

There are large numbers of trainees in basic surgical training who will seek admission to the SET program. The Team was assured that most of these trainees are expected to enter SET over the next three years. The AMC will wish for regular information about these transition arrangements.

The tension between service and educational requirements of postgraduate medical trainees is a fact of life that has to be managed by the great majority of colleges. A time of transition creates inevitable stresses in a relationship and the implementation of the new Surgical Education and Training program has identified weaknesses in existing consultative arrangements. The Team believed that the College and the jurisdictions are each eager to improve effective communication.

There are clear differences across the nine surgical training programs. While these may be appropriately related to intrinsic differences in the practice of surgery in the surgical specialties the Team urges the College to work towards common standards when these are sensible and achievable. Differences should be defensible and the reasons for them clearly explained.

All available evidence indicates that the College produces good surgeons. Over the last six years, the College has worked hard to develop curricula and define the technical and non technical competencies that define excellence in surgery and surgical training. Introduction of SET builds upon this approach by adding changes in learning and assessment methods. The Team considers these changes are educationally sound and that the introduction of SET will not decrease output of trained surgeons but may increase output slightly.

**Commendations**

A  The contribution of the College’s SET working party to the development of the Surgical Education and Training program.

B  The commitment shown by the College’s senior office bearers to the development of SET, and by their leadership of these changes.
C The Memoranda of Understanding and Service Agreements developed between RACS and the specialty societies in relation to education and training roles and responsibilities.

D The development of the nine competencies of surgical training as the basis for the definition of graduate outcomes in all disciplines.

E Definition of goals and outcomes of surgical training in all disciplines.

F The College’s willingness to accept that some trainees may achieve competence sufficient to allow early exit from the training program and its plans to facilitate this option.

G The move towards integrated surgical training with the potential to reduce both uncertainty for aspiring trainees and ‘wasted’ time spent in non-accredited training positions while awaiting selection into specialist surgical training.

H The College’s requirement that all trainees must engage in a research activity.

I The work done by the College and the specialty boards to link clearly the assessment requirements, the nine surgical competencies and the learning objectives.

J The College’s commitment to increased formative assessment, which has the potential to improve learning and instruction within surgical training.

K The College’s work on standards setting and review of examination performance.

L The College’s annual Activities Report.

M The efforts made by RACS to involve trainees in the College governance.

N The improvements made by the College to its processes for communicating with trainees.

O The commitment of surgical supervisors and trainers to their trainees.

P RACS’ commitment to renewing its support for supervisors.

Q The development of explicit accreditation standards and criteria, and a clear accreditation process.

R The early discussions within the College about ensuring that trainees experience continuity of care of the surgical patient.

S The College’s Continuing Professional Development (CPD) program, which is well developed, focuses on active learning and has high participation and compliance rates by fellows.

T The move to make publicly available on the College’s website information that will identify fellows meeting continuing professional development requirements.

U The inclusion of non-technical competencies in the College’s CPD program and the College’s provision of learning resources covering these competencies.

Recommendations

That RACS:

1. Ensure continuing support and resources for the College’s Education Section.

2. Report to the AMC on the schedule of planned changes in its educational programs and the proposed time of implementation.

3. While recognising the inherent difference between specialties, continue to ensure greater coherence in key training processes. When differences continue between specialties in
selection processes, assessment and components of training, RACS should ensure that they are supported by a clear evidence-based educational rationale.

4 Report, as part of its College Activity Report, numbers of entrants into SET1 and SET2+ and the origin of these entrants (by PGY year, whether or not BST, IMG) by jurisdiction and specialty.

5 Agree with jurisdictions on mechanisms to facilitate resolution of issues of concern, including workforce numbers. These could include (a) a high-level consultative forum, possibly along the lines outlined in this report, to meet at least twice a year, and (b) consultative arrangements at the jurisdictional level with the relevant Regional Committee (and representatives of the regional sub-committees of specialty boards) to identify appropriate posts for accreditation and to facilitate resolution of issues of concern including issues of workforce availability.

Once established, the jurisdiction-regional committee liaison processes be used to track progress on ensuring that all appropriate hospital posts are accredited for SET2+ training and that RACS’ central office is advised of progress on this issue.

6 Where jurisdictions have developed clear service expansion plans (e.g. new or expanded hospitals) accompanied by specific allocation of additional recurrent funding, RACS and jurisdictions agree, as part of the planning for those facilities, on the profile of SET2+ places to be created in the new facilities and the timing of their availability and accreditation, thus allowing additional SET1 places to be created in existing facilities in advance of the SET2+ places coming on line.

7 Recognising the different needs of the specialty groups, aim to increase the uniformity between presentation of the aims and goals of training for nine surgical specialties particularly on the website, taking account of feedback from the trainee and supervisor groups.

8 Develop concrete and evidence-based information regarding the definition of the ‘non-technical’ competencies.

9 Continue and strengthen its consultation with all groups affected by the implementation of SET, and in particular addressing communication gaps outlined above.

10 Involve health consumers and patients in any future consultation about the goals and objectives of surgical training.

11 Present to the AMC its timetable for the planned move to competency-based training and report annually on its progress.

12 Build on the increase in educational resources and facilitate the sharing of good educational practice by establishing regular and frequent meetings of specialty society and College educational staff.

13 Define the educational objectives of the research components of training and review requirements against these objectives.

14 Report to the AMC on the impact of SET on the availability of flexible training opportunities.

15 Seek congruence of assessment processes between the specialties except when differences can be justified for educational reasons.

16 Research thoroughly the strengths, weaknesses, practicalities and generalisability of the Mini-Clinical Evaluation Exercise and Direct Observation of Procedural Skills as assessment tools in the local hospital setting and make public its findings.

17 Report in annual reports to the AMC on the procedures for identification and management of under-performing trainees.
Consider whether in view of the improved in-course assessment the major summative exit examination in its present form could be reviewed.

Report on the measures of validity and reliability of assessment processes that it identifies.

Continue to publish data on timeliness and outcomes of applications from International Medical Graduates in the College’s Activities Report.

Develop and report to the AMC on its plans to evaluate the introduction of the SET program.

Introduce procedures to collect feedback on the training program from external stakeholders such as health administrators and health consumer groups.

Report in annual reports to the AMC on plans for trainee and supervisor evaluation of SET.

Report to the AMC on the evolution of the selection process, taking account of feedback from the specialty societies, the applicants and other stakeholders.

Continue to collaborate with the jurisdictions to increase the output of well-trained surgeons.

Consider how trainees can be engaged as part of a more sophisticated communication strategy regarding the SET program.

Report in annual reports to the AMC on:
- changes in the workload of supervisors after the introduction of SET
- the introduction of training for supervisors and trainers in the new work-based assessment methods
- progress in developing a process for trainee evaluation of their supervision.

Increase communication with supervisors and trainers about SET.

Consider making the SATSET course, Assessment and Management of Trainees, mandatory for supervisors and trainers.

Recommendations on accreditation

The AMC Guidelines for Accreditation list the options available to the Council in deciding on the accreditation of the training programs but do not include separate options for the accreditation of major changes to an accredited specialist medical training program. In considering the period of accreditation to be recommended, the Specialist Education Accreditation Committee has considered the options available to the Council in accrediting major changes to established medical courses.

Fixing a period of accreditation is complicated by RACS’ decision to introduce the changes encompassed by SET over a number of years. At the Committee’s request, RACS provided a timetable for introducing the range of major changes planned. This timeline identifies major implementation activities until 2010 – 2011 and progressive evaluation of SET from 2008.

The Specialist Education Accreditation Committee recommends:

(i) That the AMC grant accreditation of the Surgical Education and Training program and the continuing professional development programs of the Royal Australasian College of Surgeons until December 2011, subject to the following conditions:

(a) A satisfactory report to the Specialist Education Accreditation Committee responding to the recommendations made in this report on:

(i) Mechanisms agreed with jurisdictions to facilitate resolution of issues of concern, including workforce numbers
(ii) The development and implementation of an enhanced strategy for communication with stakeholders about SET

(ii) Evaluation of the selection process

(iii) Introduction of new in-training assessment processes, including the training of assessors

(iv) Plans to ensure greater coherence between the surgical specialties in key training processes.

The assessment of the College’s report will include a follow up visit by an AMC review team.

(ii) That in the usual annual reports to the Specialist Education Accreditation Committee, RACS comment on its response to the other recommendations in the Accreditation Report.

(iii) That in the year before expiry of this period of accreditation (i.e. 2011), the College submit a comprehensive report to the AMC. If, on the basis of the report, the Specialist Education Accreditation Committee advises Council that SET is being delivered successfully, and that RACS is maintaining the standards of education and resources necessary to support the program, the Council extend the accreditation to the maximum available period before the next AMC assessment by site visit occurs.
1 INTRODUCTION: THE AMC ACCREDITATION PROCESS

The Australian Medical Council (AMC) is a national standards body for medical education and training. One of its functions is to advise and make recommendations to the State and Territory medical boards on the accreditation of Australian and Australasian providers of specialist medical training and of their specialist medical training and professional development programs.

1.1 Background to establishment of the process for accreditation of specialist medical education and training programs

The AMC’s accreditation process aims to provide external assurance of the quality of specialist medical education, based on explicit educational standards. It is a voluntary process aimed at quality improvement.

The AMC implemented the review process in response to an invitation from the Commonwealth Minister for Health and Ageing to propose a new model for recognising medical specialties in Australia. A working party of the AMC and the Committee of Presidents of Medical Colleges, established to consider the Minister’s request, developed a model with three components:

- a new national process for assessing requests to establish and formally recognise medical specialties
- a new national process for reviewing and accrediting specialist medical education and training programs
- enhancement of the system of registration of medical practitioners including medical specialists.

The working party recommended that, as well as reviewing and accrediting the training programs for new medical specialties, the AMC should review and accredit the training programs of the existing providers of specialist medical education and training, the specialist medical colleges. It was agreed that the review process should encompass both specialist medical education and training programs and the continuing professional development programs that the colleges provide to assist their fellows to maintain their standards of professional practice.

Separate working parties developed the three elements of the model. An AMC consultative committee developed a document comprising procedures for reviewing specialist medical training programs and draft educational guidelines against which programs could be reviewed. Following extensive consultation, the AMC endorsed a revised document in July 2000.

In order to test the process the AMC conducted trial reviews during 2000 and 2001 with funding from the Commonwealth Department of Health and Ageing. These trialled the processes and guidelines by reviewing the programs of the Royal Australian and New Zealand College of Radiologists and the Royal Australasian College of Surgeons.

Following the success of these trials, the AMC implemented the new accreditation process in November 2001. It established a Specialist Education Accreditation Committee to oversee the accreditation process, and agreed on a forward program allowing it to review the education and training programs of one or two providers of specialist training each year. It confirmed the Guidelines for Accreditation, Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures, in July 2002.
1.2 Introduction to the AMC accreditation process

Historically, specialist medical colleges have coordinated the training, education and examination of medical specialists in Australia, with training in a particular area of specialist medical practice being provided by one national specialist medical college.

Typically, the specialist medical colleges have had as their mission the definition and promotion of high standards of medical practice and patient care in their specialty area, achieved through:

- setting standards of training, medical practice and professionalism
- ensuring that trainees are prepared for specialist medical practice and equipped to respond to evolution in medical practice
- promoting investigation and medical research
- promoting medical knowledge and encouraging medical specialists to continue their professional development
- public education and health education
- contributing to debates about healthcare, and wider health and social issues
- collaborating with other medical bodies nationally and internationally
- promoting health policy that supports good care and responsible decisions.

In developing its new model for recognising medical specialties and reviewing specialist medical training programs, the AMC noted the possibility of different approaches to the provision of specialist medical training in the future including the possibility that bodies other than specialist medical colleges would provide training, and the possibility of more than one provider of training in any specialist discipline.

Thus the AMC Guidelines for Accreditation do not prescribe any particular model of specialist training.

The Guidelines do, however, identify key features of successful specialist/vocational training programs. The AMC believes that specialist/vocational medical practice requires completion of a comprehensive program of advanced training and assessment including completion of:

- a broad education program in basic medical sciences and clinical skills, with objective assessment of proficiency
- supervised practical training in accredited training programs that emphasise graduated practical experience and development of a knowledge-base in the science and practice of the relevant specialty
- the requirements for fellowship of the relevant college/training organisation, including a range of structured objective assessments and satisfactory supervisors’ reports.

The structured assessments conducted during specialist training, and the progressive increase in experience and level of responsibility are integrally related so that assessments cannot be undertaken in isolation from training.

The Guidelines for Accreditation also outline the roles and responsibilities of the body that awards the qualification certifying completion of a program of appropriate specialist medical training. In addition, they indicate the roles expected of training organisations in assessing the equivalence of
overseas-trained specialists, and in providing and accrediting continuing professional development programs.

These key features of training programs and essential roles of training organisations are listed in the Accreditation Standards, which are reproduced at Appendix 1.

The Guidelines for Accreditation describe a standard process that the AMC uses to review education and training processes and programs, including continuing professional development programs.

The AMC believes that the accreditation process should:

1. assess whether the education, training and professional development programs:
   - are relevant to the objectives and outcomes determined by the training organisation
   - are appropriate in terms of modern educational methods and clinical practice
   - include appropriate assessment methods that test the trainee’s knowledge, clinical skills, professional qualities and expertise for safe and competent practice of the specialty.

2. encourage further improvements and developments in the programs being accredited and so enhance their educational quality

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

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

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

6. be focused on the achievement of objectives, ongoing development of academic standards, public safety expectations, and good outputs and outcomes rather than on detailed specification of curriculum content relevant to the specialty or discipline.

1.3 History of assessment of the Royal Australasian College of Surgeons’ education and training programs

The Royal Australasian College of Surgeons (RACS) was one of two colleges that participated in the AMC’s pilot of the specialist education accreditation program in 2001. This assessment resulted in the following decision:

That the Australian Medical Council grant the specialist education and training and professional development programs of the Royal Australasian College of Surgeons accreditation for six years, that is until 31 July 2008, subject to an annual report from the College addressing in particular the actions relating to:

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

b. The further development and specification of the College’s educational programs, including continuing professional development programs.

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

d. Development of systems for program monitoring and evaluation.

e. Requirements for selection consistent with the Medical Training and Review Panel Report (the Brennan Principles).
f. Further attention to the issues relating to 'non-accredited training posts'.
g. Improved mechanisms for formative assessment of trainees.
h. Review of the criteria and processes for accreditation of training post and institutions.
i. Review of the strategies and mechanisms for communication to and from the College, trainees, supervisors, mentors and trainers.
j. Further attention to the issues relating to assessment of overseas trained surgeons.

As the AMC was assessing the College’s training programs in 2001, the College was also undergoing an assessment for the purposes of authorisation by the Australian Competition and Consumer Commission (ACCC) of its core functions, including:

- the selection, training and examining of basic and advanced surgical trainees
- the accreditation of hospitals for basic surgical training and hospital posts for advanced surgical training, and
- the assessment of overseas trained surgeons.

Authorisation provides immunity against possible court action for conduct that might otherwise breach the competition provisions of the *Trade Practices Act 1974*. Such authorisation is granted where the ACCC is satisfied that the potential monopoly practice is of net benefit to the public.

Following an extensive public consultation process, the ACCC granted authorisation subject to a number of matters being addressed. A series of recommendations about change to the processes for development and implementation of surgical training and assessment standards accompanied the authorisation. Whilst the authorisation process had a different focus to that of the AMC accreditation process, where the content of the two reports overlapped, the ACCC findings are consistent with those in the AMC Accreditation Report.

In 2006, the ACCC decided to review the authorisation because of changes in RACS processes. RACS decided that it would not seek re-authorisation by the ACCC.

As set out in the AMC decision on accreditation, RACS has submitted annual reports to the AMC to demonstrate progress regarding the recommendations listed in the Accreditation Report. The annual reports to the AMC were each reviewed by a member of the 2001 RACS Accreditation Team, and considered by the AMC Specialist Education Accreditation Committee. These reports have showed progress in a number of areas, which has accelerated since RACS appointed a Dean of Education in 2004.

In its 2006 annual report to the AMC, RACS outlined plans for a change to structure of its education and training programs to be phased in from 2008. The existing two tiered structure, comprising a minimum two-year period of basic surgical training followed by specialist surgical training in one of the nine recognised surgical specialties, would be replaced by an integrated program into which trainees would be streamed into a chosen surgical specialty upon acceptance into the College’s program. To accommodate its new Surgical Education and Training (SET) program, the College is revising its training curricula and assessment procedures, as well as its selection processes. Medical students in their final year and medical graduates interested in surgery will be able to register with the College as potential applicants to the training program, and as part of a preparation for SET, or PreSET, receive advice from the College on the educational and training requirements for gaining selection into the SET program.

The AMC regards the implementation of SET as a major change to the accredited education and training program of RACS. As is standard practice, the AMC advised the College that its ongoing accreditation would be conditional upon an assessment of the changes prior to their introduction. The assessment, however, would be limited in scope to the SET program and the capacity of RACS to
introduce the program given the expressed timetable and the challenges posed by the broader training environment.

1.4 Assessment of a major change to the Royal Australasian College of Surgeons’ education and training programs

On the advice of the Specialist Education Accreditation Committee, in November 2006, the Council appointed Dr Robin Mortimer AO to chair the AMC’s assessment of a major change to the Royal Australasian College of Surgeons’ education and training program. Dr Mortimer was the Chair of the 2001 RACS Accreditation Team and was responsible for reviewing the annual reports submitted by RACS following this accreditation.

The AMC then began discussions with the College about the timing of the review and the process that would be followed in the review.

The AMC Council appointed other members of the RACS Accreditation Team (called ‘the Team’ in this report) in May 2007, after the College had an opportunity to comment on the individuals proposed. The members of the Team are listed in Appendix 2.

The review process has entailed the following steps:

- meetings between AMC Secretariat staff and College officers in early 2007 to discuss the scope and timing of the review
- preparation by the College of a detailed accreditation submission outlining the major change to the existing accredited education and training program
- a Team meeting in May 2007 to consider the College’s submission, plan the review and provide feedback to the College on the Team’s plans
- invitations to stakeholders to comment on the introduction of the new SET program, including organisations of trainees, other specialist medical colleges, jurisdictional health authorities, and health consumer groups
- a program of site visits in New South Wales, New Zealand, Queensland, Victoria and Western Australia held between 9 and 23 July 2007. These included meetings with supervisors, trainees, hospital administrators and specialty societies.
- a program of meetings between 23 and 25 July with College officials, including Office Bearers, members of RACS committees responsible for the training program and senior staff. At the conclusion of this program, the Team presented a statement of preliminary findings, which is reproduced at Appendix 3.

Since most of the specialist medical colleges span Australia and New Zealand, the Medical Council of New Zealand (MCNZ) is an important contributor to the AMC process. With advice from the Medical Council of New Zealand, the AMC is seeking to ensure that colleges’ accreditation submissions also address the MCNZ’s requirements and it routinely seek input to reviews from the Ministry of Health.

1.5 Appreciation

The Team is grateful to the College staff and fellows who prepared the accreditation submission and the impressive, detailed documentation that has already been prepared on the new SET program, those who managed the preparations for the review. It acknowledges with thanks the support of the RACS fellows in Australia and New Zealand who coordinated the visits to individual units and hospitals, and the assistance of those who hosted visits from Team members.
The Team is grateful to all those who contributed to the review by attending meetings and/or by lodging a submission. A list of the organisations that made a submission to the Team is at Appendix 4. A summary of the Team’s program of meetings and visits is provided in Appendix 5.

1.6 **This report**

This report contains the findings of the 2007 AMC Accreditation Team on the College’s plans to introduce the new Surgical Education and Training program and its readiness for this change.

The report is not intended as a comprehensive review of the College’s education, training and continuing professional development policies and procedures or as a review of the response by RACS to the more than 40 recommendations made in the 2002 AMC Accreditation Report. The College has reported annually on its response to these recommendations.
2 ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Founded in 1927, the Royal Australasian College of Surgeons (RACS) is registered as a corporation with the Australian Securities and Investment Commission and is subject to the requirements set by the Corporations Act 2001. It is chiefly concerned with standards, training and continuing professional development as it relates to surgical practice in Australia and New Zealand.

The structure of the organisation is established by its Articles of Association. These Articles list the objects of the College as among others:

- to cultivate and maintain the highest principles of surgical practice and ethics
- to promote the practice of surgery under proper conditions by securing the improvement of hospitals and hospital methods
- to arrange for adequate postgraduate surgical training at universities and hospitals and to conduct examinations of candidates for admission to fellowship
- to promote research in surgery
- to bring together the surgeons of Australia and New Zealand periodically for scientific discussion and practical demonstration of surgical subjects
- to consider all questions affecting the interests of the College and to initiate and watch over and if necessary to petition Parliament or promote deputations in relation to measures affecting the College.

RACS is governed by a Council. This body comprises 16 fellows elected from the membership at large and nine from the surgical specialties, and other members coopted by Council under defined conditions. Between meetings of Council, an Executive Committee of Council is empowered to make decisions on the ongoing direction of the College and its business.

Council members work in an honorary capacity.

Also working in an honorary capacity are the surgeons who make up the New Zealand, State and ACT Committees, as well as the 32 Committees of Council which have been formed to address issues affecting surgeons in a wide variety of areas. These surgeons may also contribute fully to the activity of their own specialist society.

The College comprises some 7,100 fellows. About 90 per cent of surgeons practising in Australia and New Zealand are fellows of the College. There are 1,700 trainees registered with the RACS: 737 in the basic surgical training program and 963 who have proceeded to specialist surgical training in one of nine specialty streams.

The College headquarters are in Melbourne. There are regional offices of the College in each Australian State and in Wellington, New Zealand. These offices are chiefly concerned with local administrative matters and serve a local committee with a Chairman and office bearers. The interaction between the regional training committees and the regional offices varies from specialty to specialty.

2.1 Governance of training

At the time of the last AMC assessment of the College’s education and training programs in 2001, the College had recently revised its organisational structure. Further changes have occurred since then.
The work of the College is now concentrated in four portfolios. As documented in the College’s strategic plan for 2006-2008, these are: relationships, resources; education and fellowship.

The staffing and committee structures of the College largely are organised according to these portfolios.

Within the education portfolio, with which this review is principally concerned, the key committees of the College are as follows:

- **The Education Board** is the peak Board responsible for the management and administration of the educational activities of the College. The Education Board is accountable directly to Council. All other boards and committees within the Education Portfolio are accountable to the Education Board.

- **The Board of Basic Surgical Training** develops policies and processes relating to selection, clinical supervision, progression and assessment of basic surgical trainees. The Board is responsible for the development and maintenance of a curriculum and examinations. The Board is responsible to Council via the Education Policy Board. The Board of Basic Surgical Training also advises the Education Board on issues relating to skills courses and has contributed to the development of the SET program.

- **The Board of Specialist Surgical Training** is responsible for the regulation and administration of the College’s specialist surgical training programs in Australia and New Zealand and in some regions of Asia.

- **The Specialty Boards** of the College are responsible for the delivery of the specialist surgical training programs, accreditation of hospital posts, and the selection, assessment and supervision of specialist surgical trainees. Specialty boards are appointed for each of the nine surgical specialties: cardiothoracic surgery; general surgery; neurosurgery; orthopaedic surgery; otolaryngology, head and neck surgery; paediatric surgery; plastic and reconstructive surgery; urology and vascular surgery. These boards are responsible for advising Council on training and accreditation via the Board of Specialist Surgical Training and the Education Board. Specialty boards are governed by the Articles of Association and the policies of the College. Where specialty boards have regional training committees, the specialty board is responsible for the activities of those subcommittees.

For some specialties, the administration of the surgical education and training program is delegated to the corresponding external society or association in accordance with the service agreements. The administration of surgical education and training for all other training programs is undertaken by the College. The process of implementation undertaken by the Specialist Society or Association in line with the Service Agreements may vary between the specialties.

Regional offices deal with much of the day-to-day College affairs. These are governed by individual **Regional Committees and the NZ National Board**, the roles of which, according to the College, are to:

- communicate the decisions of Council to local members
- provide educational opportunities to local trainees and fellows
- provide advice to Council on local issues
- assume responsibility for local issues and if necessary providing recommendations to Council

In the case of general surgery in Australia and New Zealand, and plastic surgery in New Zealand, the Regional Committees administer selection and training on behalf of the specialty.
Each of these regional offices provides a focus for the activities of the College, the specialty societies and trainees at a local level. However, any regional training sub-committee relates to the Training Board for that specialty. The College also sees a role for the regional committees in dealing with the local health department.

A recent initiative has been the establishment of a **Board of Regional Chairs**, a key aim of which is to permit more effective communication to the Council and Head Office about issues pertaining to the local/regional level.

**Figure 1** below depicts the current governing committee structure within the education portfolio as provided by the College in its submission. The introduction of SET will require changes to this.

Figure 1. Current Committee Structure within Education Portfolio

<table>
<thead>
<tr>
<th>Council</th>
<th>Education Board</th>
<th>Censor in Chief’s Decisions Review Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Board of Basic Surgical Training</td>
<td>Board of Specialist Surgical Training</td>
</tr>
<tr>
<td>Anatomy Committee</td>
<td>Board of Cardiothoracic Surgery</td>
<td>Board of Urology*</td>
</tr>
<tr>
<td>ASSET Committee</td>
<td>Board in General Surgery*</td>
<td>Board of Plastic and Reconstructive Surgery*</td>
</tr>
<tr>
<td>BST Examinations and Assessment Committee</td>
<td>Board of Orthopaedic Surgery</td>
<td>Board of Paediatric Surgery</td>
</tr>
<tr>
<td>BST Surgical Supervisors Committee</td>
<td>Board of Otolaryngology, Head &amp; Neck Surgery*</td>
<td>Board of Paediatric Surgery</td>
</tr>
<tr>
<td>CCtSP Committee</td>
<td>Board of Paediatric Surgery</td>
<td>Board of Otolaryngology, Head &amp; Neck Surgery*</td>
</tr>
<tr>
<td>Clinical Committee</td>
<td>Board of Plastic and Reconstructive Surgery*</td>
<td>Board of Urology*</td>
</tr>
<tr>
<td>Curriculum Review Committee</td>
<td>Board of Urology*</td>
<td>Board of Vascular Surgery</td>
</tr>
<tr>
<td>EMST Committee</td>
<td>*Some Specialty Boards have regional/New Zealand training committees reporting to them</td>
<td></td>
</tr>
<tr>
<td>Pathology Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiology Committee</td>
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</tr>
</tbody>
</table>

Development of the SET program has been the responsibility of the SET Working Party since June 2006. The working party, which reports to the Board of Education, has broad terms of reference including:

- developing an integrated surgical training program building on existing resources and processes
- establishing pathways for training that will not disadvantage current or future trainees.
• establishing a course of action to deal with both trainees who are identified as not meeting training requirements early in the program and trainees in the current program who may wish to transfer to the new program.

It has been chaired by the Censor in Chief and included the members of the Education Board, the Chairs of the nine specialty boards and coopted Council members. It has included both jurisdictional and trainee representatives. It has been supported by a substantial number of staff.

2.1.1 Implications of the introduction of SET for the governance of training

Under the SET program, basic surgical training (BST) is to be abolished. Those accepted into the new training program will be selected directly into specialty training. The individual specialty boards, previously responsible only for the advanced surgical training component of the program, will become responsible for the governance and administration of the whole training program in their specialty, therefore extending their reach.

The role of the Board of Basic Surgical Training will thus shift in emphasis. The Board will continue to be responsible for the training of the cohort of continuing basic surgical trainees during the transitional period. Under SET its role will be principally to oversee the activities generic to all surgical specialties. These activities include the administration of the Basic Sciences Examination and the Objective Structured Clinical Examinations, the delivery of broad based educational courses, and collaborating with the specialty boards to create greater uniformity in selection processes and requirements. The Board will need to be appropriately re-named.

A College discussion document has been developed proposing that the SET working party and the Board of Specialist Surgical Training be replaced by a Board of SET which will oversee the whole of SET training. This Board of Surgical Education and Training will report to the Education Board.

2.1.2 Team’s findings

The Team’s discussions with College officers confirmed support for the changes implemented in the governance of the training program, which were seen to provide a good balance between governance by College fellows and management by staff. The Team concurs with the view that the College fellows are well supported by professional and skilled College staff in the management and delivery of training.

The College has demonstrated a commitment to providing adequate resources for its educational and training activities. Changes of the magnitude of the SET program require significant additional resources. It is important that at this busy time the College Education section are allowed time to reflect on changes in international educational theory and practice.

The Team recognises the enormous workload that fellows and staff have accepted in designing and implementing SET. It commends in particular the contribution of the SET working party. The representation of relevant College stakeholders on this group is contributing to their greater understanding of the totality of surgical training and to sharing of good practice between the specialties.

The Team was impressed by the commitment shown by the College’s senior office bearers to the development of SET and by their leadership of these changes.

Understandably, the College’s focus to date has been on determining the aims of SET and on the steps required for initial implementation such as the selection of trainees, the arrangements for trainees currently in basic surgical training, and the accreditation of posts for SET1. The College’s SET
Development Timeline does not make clear the College’s timelines for the progressive introduction of other initiatives, such as changes to assessment approaches or how it focus on trainees’ achievement of surgical competencies rather than the time spent in training.

The College’s statement of aims suggests that these changes are planned to evolve over time and that early in this process changes in the educational program are minimal. During discussions with the Team, College officers suggested that the timeframe for these changes is three to four years. The Team considers that it would be useful for the College and its external clients to develop a schedule of planned changes and proposed time of implementation.

Commendations

A  The contribution of the College’s SET working party to the development of the Surgical Education and Training program.

B  The commitment shown by the College’s senior office bearers to the development of SET, and by their leadership of these changes.

Recommendations

That RACS:

1  Ensure continuing support and resources for the College’s Education section.

2  Report to the AMC on the schedule of planned changes in its educational programs and the proposed time of implementation.

2.2  Key relationships and external environment

2.2.1  Specialty societies

The specialty boards will be responsible for the governance of the individual training programs, and the actual delivery of the training program will be contracted to the 13 specialty societies/associations representing the nine recognised surgical specialties. Under the SET program, the College training program, in fact, is a ‘sub-specialty’ training program: trainees graduate as fellows of RACS, but are recognised as members of recognised specialties. However the roles between the College and the specialty societies vary substantially across the nine specialties. This arrangement will not be changed under SET.

The relationships between the College and these organisations are defined by Memoranda of Association and Agreements. The 2002 AMC Accreditation Report recommended that RACS develop such a framework to formalise the relationship between the College and the societies, with strong emphasis on delineating the respective responsibilities and accountabilities of each party. The Team found that considerable progress in this area has been made.

As SET is introduced, the nature of these relationships and the frameworks in which they are formalised will require further refinement. The Team noted that the current service agreements governing the funding, development and delivery of the training programs are under review, and this is appropriate given the changes that are occurring.

Given the prominence of the specialty boards and the specialty societies within the SET program and that each is distinct and has developed different emphases, priorities and approaches to training, the Team explored in details some of the implications of SET for each surgical specialty training program.
The Team recognised that the specialty boards and societies are critical to the success of surgical training in Australia and New Zealand and bring a wealth of experience and knowledge to the processes of surgical education. Nevertheless, the AMC is accrediting the RACS training program, not nine separate programs. What the Team looked for was coherence in selection, training and assessment across the specialties with differences between the specialties being able to be justified by a clear educational rationale related to the distinct nature of the discipline.

The Team found that differences between the specialty programs impact adversely on trainees with differences in application format, weighting and criteria. There were also reported differences in what was acceptable as an ‘Intensive Care Unit (ICU) term’ between specialties: did it mean ICU, High Dependency Unit or simply a term where patients who were critically ill predominated? This impact on trainees is possibly exacerbated because of the problems associated with the transition to the new Surgical Education and Training Program.

**Figure 2** shows the difference in relative weightings for selection into SET 1 for 2008. The Team was pleased to see that components of the selection processes and their weighting will become more coherent in 2008 (Figure 2).

### Figure 2: Components and Relative Weighting for Admission into SET 1, 2008

<table>
<thead>
<tr>
<th>Component</th>
<th>Cardiothoracic</th>
<th>General Surgery</th>
<th>Neurosurgery</th>
<th>Orthopaedic</th>
<th>Otolaryngology</th>
<th>Paediatric</th>
<th>Plastic &amp; Reconstructive</th>
<th>Urology</th>
<th>Vascular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured CV</td>
<td>20%</td>
<td>25%</td>
<td>20%</td>
<td>25%</td>
<td>20%</td>
<td>10%</td>
<td>25%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Clinical Referees Reports</td>
<td>40%</td>
<td>45%</td>
<td>35%</td>
<td>35%</td>
<td>360″</td>
<td>20%</td>
<td>50%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Professional Performance Assessment (# Required)</td>
<td>Hospital Reports (2)</td>
<td>40% (2)</td>
<td>(3) 40%</td>
<td>(3) 40%</td>
<td>(3) 40%</td>
<td>(3) 40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-structured interview</td>
<td>40%</td>
<td>30%</td>
<td>45%</td>
<td>40%</td>
<td>40%</td>
<td>30%</td>
<td>25%</td>
<td>45%</td>
<td>45%</td>
</tr>
</tbody>
</table>

It can be seen that there are still significant differences between the specialties. There may also be difference in weighting within each selection method e.g. relative weighting for conference attendance on the curriculum vitae may differ between specialties.

There are also differences in components of training. The specialty of neurosurgery, for example, requires a year of research training, an experience not required in any other specialty.

The Team acknowledges the enormous progress made in bringing together nine specialty boards and in establishing a unified process. Documentation presented as part of the accreditation submission, and information gathered in interviews and site visits, did not however enable the Team to discern any educational rationale for the observed differences in key program attributes. In contrast, trainees (especially those in BST seeking admission to SET) experienced frustration with specialties’ differences that appeared to them as idiosyncratic rather than evidence-based. The Team believes that these differences should and will be minimised as the SET program evolves.
2.3.2 Commonwealth, State and Territory health authorities

The College and the New Zealand, Australian and State and Territory health authorities (the jurisdictions) are inextricably linked in the education and training of the future surgical workforce. This is because:

- most trainees occupy service delivery roles in the public hospital system
- the College relies on the time of public hospital staff to supervise trainees and contribute to other College functions. This is often in addition to their recognised workload.
- training and clinical services occur at the same time and in the same location (e.g. by a surgeon showing a trainee how to perform a particular operation)
- College trainees graduate to become the surgeons necessary to meet the staffing and service needs of the public (and private) health services of the future.

A time of transition creates inevitable stresses in relationships and the implementation of the SET program has identified difficulties in existing consultative arrangements. Both the College and jurisdictional representatives acknowledged that consultation on the new arrangements had not progressed smoothly. The Team endorses the need for more meaningful dialogue between the College and health authorities.

In both written and oral submissions, jurisdictional representatives raised a number of areas of concern. These included:

- the potential for increased workload for supervisors from the new assessment tasks inherent in the new program
- industrial awards which require SET and PreSET hospital staff to be treated equally in the workplace, but cause difficulties in accommodating expectations of trainees to be released for College-required experiences
- the need for employers to maintain their right to veto employment of trainees referred to them as part of a rotation
- the potential for SET1 requirements to reduce the availability of trainees for service delivery and thus increasing significantly the workload on doctors registered as PreSET or non-SET clinical personnel
• the potential for the streaming into specialties to reduce rural and regional rotations at the expense of service delivery in those areas

• the risk that ‘undesirable’ rotations and functions (e.g. night duty) may become concentrated in a reduced pool of non- or PreSET personnel.

The tension between jurisdictions and the College is exacerbated by uncertainty about key aspects of the SET program and its implementation. These may be resolved with time and more information. Nonetheless, the Team does not recommend a ‘wait and see’ strategy. Rather, the Team proposes new consultative structures as described below.

Some jurisdictional representatives, along with the Health Workforce Principal Committee recommended deferring introduction of the SET program to allow time for greater clarity of the impacts on surgeons and services, and resolution of the above issues.

In reality, the new program is not being introduced in a single year: the existence of a large BST cohort who will seek enrolment in SET 1 or SET 2+ places will mean that any impacts will be phased in over the period 2008 to 2010 rather than impacting in a single year which would create intolerable stress on services.

The Team noted that the jurisdictions have representation on a number of College committees and working parties, but that this has not been as effective a communication channel as either party would have wished. Whilst the Team acknowledges that effective working relationships exist in some jurisdictions, it is clear that additional arrangements need to be introduced and formal consultation mechanisms established (including at the appropriate regional level).

At the national level in Australia, a high level committee should be established which meets at least twice a year involving senior representatives of the College (President, President-elect, Censor-in-Chief etc) and representatives from the jurisdictions, including the chair of the Health Workforce Principal Committee. The jurisdictional representatives should report directly to the relevant jurisdiction’s Chief Executive. It is important that Communiqués are issued after such meetings to facilitate feedback to those not present including hospitals. The Team also recommends to the jurisdictions that effective mechanisms for communicating information from their representatives on RACS committees be established.

As the College is bi-national, it may indeed be appropriate for this forum to include representatives from both Australia and New Zealand.

Jurisdictions also raised concerns about the potential impact of the introduction of the SET program on workforce numbers. Although the number of doctors entering SET will be much lower than entered basic surgical training, the Team maintains that this will not reduce the number of qualified surgeons produced. The number of surgeons graduating is effectively limited by the number of accredited latter year training posts. In contrast to the old BST arrangements, the new SET program guarantees latter year specialty training posts to all who gain entry into the SET program. The number of SET1 posts is thus itself limited by latter year posts (taking into account natural attrition rates in each specialty, and including transfer to another specialty program through competitive selection.

It is possible that the new SET arrangements may in fact yield a marginal increase in graduations over time. This is because the SET program is likely to reduce the length of training by eliminating the current ‘bottleneck’ between basic surgical training and specialist surgical training that sees a number of BSTs having to wait years before being accepted in specialist surgical training. It is also possible that the planned development and introduction of more regular formative assessment and competency-based assessment will mean that a number of trainees may be able to achieve fellowship sooner than under the present time-based system. Some, of course, may take longer.
The surgical workforce supply may also be increased if entry into specialty training were to occur earlier thus increasing the number of years of specialty practice.

Given the ageing and increasing population, it is critical that all appropriate posts in the public and private sectors be used to produce the workforce required to meet service needs. Jurisdictions were very concerned that any reduction in trainees entering specialist training because of problems in the transition to the SET program would have serious consequences five to seven years later. This issue must be monitored extremely closely by the College, jurisdictions and the AMC.

Adequate supply of surgeons is a shared responsibility of the jurisdictions and the College. A key task of the consultative arrangements discussed above would be to ensure effective bi-national and regional consultation on workforce issues. This is especially critical in jurisdictions that are expanding service capacity and specific arrangements need to be made to plan an increased workforce to provide increased capacity.

The issues raised in this section may also be equally applicable to other colleges and so it may be appropriate for the Royal Australasian College of Surgeons to raise these issues with the Committee of Presidents of Medical Colleges.

Recommendations

That RACS:

4 Report, as part of its College Activity Report, numbers of entrants into SET1 and SET2+ and the origin of these entrants (by PGY year, whether or not BST, IMG) by jurisdiction and specialty.

5 Agree with jurisdictions on mechanisms to facilitate resolution of issues of concern, including workforce numbers. These could include (a) a high-level consultative forum, possibly along the lines outlined in this report, to meet at least twice a year, and (b) consultative arrangements at the jurisdictional level with the relevant Regional Committee (and representatives of the regional sub-committees of specialty boards) to identify appropriate posts for accreditation and to facilitate resolution of issues of concern including issues of workforce availability.

Once established, the jurisdiction-regional committee liaison processes be used to track progress on ensuring that all appropriate hospital posts are accredited for SET2+ training and that RACS’ central office is advised of progress on this issue.

6 Where jurisdictions have developed clear service expansion plans (e.g. new or expanded hospitals) accompanied by specific allocation of additional recurrent funding, RACS and jurisdictions agree, as part of the planning for those facilities, on the profile of SET2+ places to be created in the new facilities and the timing of their availability and accreditation, thus allowing additional SET1 places to be created in existing facilities in advance of the SET2+ places coming online.
3 THE COLLEGE’S DEFINITION OF GRADUATE OUTCOMES

3.1 AMC accreditation standards concerning the program of education and training

The AMC requires the specialist medical college to have determined the goals for each program and have processes to determine the broad roles of practitioner in the discipline.

3.2 Goals/outcomes for surgical training

The stated aim of the surgical training program is to ‘produce fully fledged surgeons of an appropriate standard, ready for unsupervised practice, able to function independently or as part of a multi-disciplinary team and to be the ‘most effective deliverers of patient care that is possible’.

RACS acknowledges that the number of qualified surgeons in Australasia will continue to be a concern due to population growth, population aging and alteration in the demographics and work-base of surgeons. The College does not however see its role as regulating the number of surgeons qualifying each year. Rather, it aims to concentrate on the quality of the product. The College does wish to participate with the jurisdictions in workforce planning.

Prior to the proposed introduction of SET, RACS produced a list of competencies for surgeons and surgical trainees. These are:

- professionalism and ethics
- scholar and teacher
- health advocacy
- management and leadership
- collaboration
- communication
- medical expertise
- judgment – clinical decision-making
- technical expertise

These nine principles develop the CanMEDS\(^1\) seven roles of specialists by adding two competencies which are considered significant to surgery: Technical Expertise and Judgement – Clinical Decision Making.

These competencies now form the basis for the curricula of all nine surgical groups and are intended to be reflected in selection and formative and summative assessment during Surgical Education and Training (SET). As such, they also form the basis of the goals and outcomes of surgical training.

Team’s findings

The Team commends the substantial work by RACS to articulate its view of the competencies necessary to practise as an independent surgical specialist in the Australian and New Zealand health systems. As statements of expectations, these are very clear. Since the 2001 AMC assessment, the

\(^1\) Royal College of Physicians and Surgeons of Canada’s CanMEDS 2005 Physician Competency Framework http://rcpsc.medical.org
College has also focussed on linking the content of its training programs with more clearly defined objectives and desired competencies and to appropriate assessment procedures.

In all specialties there appears to have been particular concentration on technical expertise as a competency with all specialty groups having a Mind-Map of the various areas in which they believe graduates of their program should be competent at the time of completion of training. This is available through the RACS website. The presentation of the information and the range of information available vary considerably from specialty to specialty.

For most groups, this syllabus style representation is expanded into a more modern curriculum representation, which for some specialty groups also encompasses some ‘non-technical’ modules. This remains patchy, however, and most specialty groups use the College’s definitions of goals for these non-technical areas. The College has stressed to the Team that curriculum development is a work in progress. As the curriculum is developed, the AMC will wish the College to report on how it defines in more detail the competencies in these non-technical areas.

Many trainees appeared unaware of the requirement for acquisition of non-technical competencies as part of their training and practice, and many supervisors and trainers felt that these competencies were often difficult to assess and quantify. This view was to some extent echoed by the SET working party. There is evidence in some specialty groups of work towards encompassing all areas of competence in training and assessment frameworks. The AMC Team was assured that this was also an area which was earmarked for further work by the SET team.

With the introduction of SET, the College has made a commitment to the introduction of competency-based training and the partial phasing out of entirely time-based training. This is a major and commendable aim which has however not yet been realised by similar educational bodies in Australia or elsewhere. At this early stage, there is little evidence that competency-based training has yet been introduced but the Team understood that planning is occurring as part of the evolution of change.

<table>
<thead>
<tr>
<th>Commendations</th>
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</table>

Recommendations:

That RACS:

7  Recognising the different needs of the specialty groups, aim to increase the uniformity between presentation of the aims and goals of training for nine surgical specialties particularly on the website, taking account of feedback from the trainee and supervisor groups.

8  Develop concrete and evidence-based information regarding the definition of the ‘non-technical’ competencies.
3.3 Consultation about the goals/outcomes

The available evidence suggests that the College produces good surgeons and this is a major strength of the current training program. Alterations to the training program have been designed to build on current strengths.

The College has been largely successful in engaging a number of bodies in the consultative process. In particular there has been significant involvement of groups from within the College – namely the specialty groups and societies, the supervisors and trainees. In addition, the College has utilised the knowledge of its own fellows with educational expertise and interest to appraise evidence from other colleges both in and outside Australasia. Notably, however, there has been no consultation with health consumers.

As with any significant change, the introduction of SET has been associated with a high level of confusion and anxiety among potential users of the program. Potential trainees interviewed by the Team were often anxious and somewhat confused; trainers and supervisors were mostly confused and jurisdictional representatives had mostly high, but variable levels of both confusion and anxiety, the degree of which appeared to correlate with their level of engagement in the process.

This confusion and anxiety appears to reflect uncertainty about the implementation of SET and the rapidity with which changes are being introduced. This is exacerbated by the lack of published timelines for introduction of the many changes associated with introduction of SET.

Recommendations

That RACS:

9 Continue and strengthen its consultation with all groups affected by the implementation of SET, and in particular addressing communication gaps outlined above.

10 Involve health consumers and patients in any future consultation about the goals and objectives of surgical training.
4 THE CURRICULUM AND TRAINING PROGRAM

4.1 AMC accreditation standards concerning the program of education and training

In relation to the program of education and training, the AMC requires the specialist medical college to:

- set a curriculum that enables trainees to achieve these goals, which specifies the educational objectives for each component, details the nature and range of clinical experience required to meet the objectives, and outlines the syllabus of knowledge, skills and professional attitudes to be acquired
- certify completion of training by a diploma or other formal award.

4.2 The curriculum framework

The current training framework has two tiers based on a variable period (between two and four years) of basic surgical training, during which the basic science and clinical examinations and a number of courses must be completed. This is followed by a competitive selection process to gain entry to a specialist surgical training program, the length of which varies depending on the specialty. The minimum specialist training program is four years, and thus the minimum complete training time is six years. This can be considerably longer, however, depending on the specialty, the availability of training positions and the trainee.

The curriculum framework is centred on the RACS nine surgical competencies in a syllabus style format for each of the specialty groups.

Trainees are expected progressively to acquire the competencies described in the preceding section, and to demonstrate these through clinical skills, patient care and professional judgement across the following domains:

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

Within this framework, the core teaching and learning experiences include teaching modules, accredited clinical experiences, skills courses and a research project. These are described in detail later.

The proposed introduction of the SET program sees a significant change to the overall framework of the training program which RACS intends to introduce progressively. The College regards SET as a substantial advance in the training of surgeons in Australia and New Zealand. It has indicated that SET will incorporate the most advanced approaches to medical training from around the world, whilst retaining the best of the existing training programs.

Trainees will be selected directly into one of the nine specialty training programs. From the beginning of training until they leave the program, their clinical experiences and assessments will be under the direction of the Board of the specialty into which they have been selected. Assuming appropriate performance and achievement of other requirement, trainees will progress through surgical training without having to undergo a second selection process. In most specialties, but not neurosurgery or
urology, the specialty board will permit trainees who have not successfully completed the examination requirements to enter SET2, providing all other requirements have been completed.

Concurrent with the introduction of SET and the phasing out of BST are:

- the intended introduction of competency-based rather than time-based training
- the introduction of new in-training workplace based assessments
- increased emphasis on non-technical competencies
- consolidation of procedures for remediation and removal of poorly performing trainees from the training program.

These issues will be addressed elsewhere in the report.

**Team’s findings**

The structure of SET is clearly designed to address the ‘bottleneck’ in moving between the BST and SST components of the program. Selection both to BST and SST is competitive, but there are significantly fewer accredited SST posts available in any given year than there are trainees who have completed the requirements of the BST. Figures provided to the Team indicate that up to 50 per cent of trainees applying for selection in an SST program are unsuccessful in any year. This has had the effect of extending the average time to fellowship. Some doctors may spend years unsuccessfully applying for selection into specialist surgical training before realising that they may be better suited for training in another discipline.

The plans to address these concerns are laudable.

The intention to streamline training in the early years has however caused significant (although variable) disquiet amongst the jurisdictions. As noted in Section 2 of this report, some employers are speculating that requests will be made to give SET trainees priority for required experiences and learning opportunities over the larger pool of junior doctors not on or registered as interested in the Surgical Education and Training Program. In some jurisdictions this would breach award conditions. The reality of this will only become clear in time.

There have always been differences between the specialist surgical training programs of the nine specialties. Under SET, there is no common initial period, and the variation commences from the beginning of training. In the early stages of implementation, this is likely to cause some problems for employers in the coordination of training. In addition, College fellows used to receiving new trainees with significant surgical experience will be presented with younger doctors with fewer surgical skills. Continued communication with both employers and supervisors about the different expectations and training requirements will be necessary during this period.

During the review, it became clear that RACS does not intend to meet all of the objectives of SET in the first year of implementation. The initial impact of SET will be the abolition of the current structure of surgical training and dramatic change to the early phases of training, with little (if any) change in 2008 to the latter years of the training program. Specialist surgical training has become SET2+. As a result, there is little evidence of alteration in the curriculum framework in SET 2+ in any specialty.
The move towards integrated surgical training with the potential to reduce both uncertainty for aspiring trainees and ‘wasted’ time spent in non-accredited training positions while awaiting selection into specialist surgical training.

4.3 Curriculum content

Figure 3 depicts the structure of the SET program as provided in the College documentation.

![Figure 3: Proposed SET Framework](image)

The specialty boards are, with the introduction of SET, revising the curriculum framework of each specialty training program in concordance with the aim of the new training program to reduce training irrelevant to eventual practice. In general terms, SET1 aims to replace BST. The skills courses currently completed in BST will remain much the same, but the clinical experiences will be more...
focused on, and more closely aligned with, the long term aims of the specialty training program. The first year of surgical training (SET1) will incorporate some of the current training requirements of BST1 and much of the current BST2.

Each of the specialty programs comprises a minimum of five years’ training (SET1 to SET5+). The nature and structure of these years are stated to be ‘very similar’ to the current specialist surgical training. The College states that the current SST program includes the following processes which remain applicable for SET2:

- defined graduate outcomes
- specialty-specific curriculum requirements
- research requirements
- accreditation processes to identify and establish training posts
- policies regulating all aspects of training
- representation of trainees and the trainees’ organisation on major committees.

The curriculum is built around the following core elements:

- **Modules** – these describe the competencies that trainees are expected to achieve within each of the specialties. Each specialty has developed modules specific to the discipline. Cardiothoracic Surgery has, for example, developed 12 modules each designed to develop and assess competencies core to the discipline (e.g. in the areas of Coronary Heart Disease, Trachea and Bronchi, Thoracic Trauma etc). Each module lists the rationale, competencies to be acquired, training resources available, assessment methods, and learning opportunities and methods. Trainees do not need to complete modules in any particular order.

In addition to specialty specific modules, there are modules relating to non-technical competencies which are generic to all specialties.

- **Clinical Experiences** – trainees rotate through accredited training posts to accumulate the experience required to develop proficiency in the chosen specialty. It is the responsibility of the specialty boards to manage the allocation of trainees across the available posts to ensure that each trainee gains the widest possible experience and achieves the required case-mix. Each of the nine surgical specialties has stated the clinical experience requirements for different stages in the SET program. In most cases, these are little changed from the existing specialty surgery training program requirements for SET2+. Each of the specialties, however, has integrated clinical experiences relevant for SET1 into its specialty training program following the abolition of the existing Basic Surgery Training program. Most specialty boards require in SET1 a period of clinical experience in their specialty. All but two of the specialties (orthopaedic surgery and neurosurgery) mandate that the trainees gain experience in SET1 in a number of other surgical disciplines.

In addition to the clinical rotations specified within each specialty program, several of the specialty boards require trainees to complete a clinical rotation in an acute high intensity environment such as an emergency department, critical care, vascular, burns or transplant unit as either a prerequisite for selection into the SET program or a component of SET1.

- **Courses** – the College has developed a number of courses which address technical competency, and which trainees currently complete during basic surgical training. Under SET, most specialties

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will require trainees to complete at least two of these early in their training, and most will require all three. The courses are:

- Australian and New Zealand Surgical Skills Education and Training (ASSET) includes two modules on skills in open surgery, one on musculoskeletal injury and one on minimal access surgery.
- Care of the Critically Ill Surgical Patient (CCRISP) focuses on the prevention of organ failure through clinical expertise and attention to clinical detail, offering a systematic approach to the assessment and management of these patients and their problems.
- Early Management of Severe Trauma (EMST) is an intensive course in the management of injury victims in the first 1 to 2 hours following injury, with emphasis on life saving skills and systematic clinical approach.

Other courses offered by the College include Critical Literature Evaluation and Research, which is designed to provide tools to undertake critical appraisal of surgical literature and to assist surgeons in the conduct of clinical trials, and the Statistics for Surgeons workshop which aims to increase the conceptual understanding and practical skills in medical statistics as it is commonly applied to surgical clinical research.

In addition to these, the College is developing a series of skills training courses utilising simulated environments, and individual specialty groups require trainees to successfully complete courses specific to that discipline.

- **Research** – prior to sitting the final Fellowship Examination, trainees are required to complete an approved research project. Neurosurgical trainees are required to complete a whole year of research. This is not mandated for any of the other subspecialties.

In drawing these elements together, the College emphasises the role of supervisors and assessors, the use of appropriate assessment tools and methodologies, and the accreditation of training posts.

**Team’s finding**

Over the last six years the College has worked towards the development of curricula and the definition of the technical and non-technical competencies that define excellence in surgery and surgical training. The Team commends this. Introduction of SET builds upon this approach by the plans to add changes in learning and assessment methods. The Team considers these changes to be educationally sound.

The College wishes to move, in time, to competency-based training. This is a laudable but ambitious goal. The Team would ask the College to present a timetable for these changes. The willingness to accept that some trainees may achieve competence sufficient to allow early exit from the training program and the fact that some trainees have already done so, for example in urology, is impressive.

Several of the specialty societies have appointed Educational Officers to aid in development and review of their training programs. There are opportunities for the College to build on this increase in educational resources and to facilitate the sharing of good educational practice by establishing regular and frequent meetings of society and College educational staff.

The College has extensive curriculum documentation which requires further development. As noted above, the curricula vary from specialty to specialty. The Team acknowledges that there are clear differences across training programs. These may be appropriately related to intrinsic differences in the practice of surgery in the surgical specialties but as the Team has recommended in Section 2 of this report, the College should continue to work towards common standards when these are sensible and can be achieved.
The Team heard concerns that early entry to a subspecialty training program without surgical experience outside that specialty might lead to an unnecessarily narrowly focussed surgeon. The Team noted that some specialties still will require trainees to develop skills across a number of specialty areas and applauded this.

Recommendations

That RACS:

11 Present to the AMC its timetable for the planned move to competency-based training and report annually on its progress.

12 Build on the increase in educational resources and facilitate the sharing of good educational practice by establishing regular and frequent meetings of specialty society and College educational staff.

4.4 Opportunities to engage trainees in research

The College states that current basic surgical trainees are encouraged to consider undertaking research projects as one of the elective rotations within their clinical placements. Trainees can undertake full-time research during BST for 12 months or more, provided that they are under the supervision of an experienced supervisor and enrolled in a higher degree at a university. Applications to have an accredited year of research recognised towards BST must be made in advance.

The research requirements of SST will continue in SET. The College submission states that all specialist surgical trainees must complete an investigative project prior to presenting for the Fellowship Examination. Trainees must complete one or more of the following:

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

Specialist surgical trainees are able to apply prospectively for recognition and credit for periods of full-time research. The College offers a number of scholarships to encourage this activity. Trainees who wish to undertake formal research training with a view to an academic surgical career may complete a formal combined FRACS/PhD pathway. The College states that the FRACS/PhD pathway only extends the duration of training by one year, and twelve months of PhD research can be counted towards the research component of SST.

Team’s findings

The College’s requirements are in keeping with the AMC’s view that all trainees should be research literate, and that there should be opportunities for some to pursue an extended period of research activity.
Trainees reported that there were few practical opportunities to undertake full-time research projects during basic surgical training, although they acknowledged that research was well regarded in the application process for SST and also for SET. As a result, some trainees reported attempting to participate in research projects in addition to their clinical responsibilities during BST. It appears that opportunities to undertake research during SET1 will be limited, because of the examination and course requirements of that year.

Despite the generic requirements for completion of a research project, there are distinct and specific requirements within the nine surgical specialty programs in the current SST program. These differences will continue in SET. Some specialties allocate points towards research activities, with requirements additional to those stated above. One specialty (neurosurgery, as noted above) requires an elective year of compulsory full-time research after SET2 or SET3, although the purpose and educational or research outcomes from this elective year do not appear well defined. Whilst the Team felt that trainees should be encouraged to spend periods of time undertaking full-time research during their surgical training, the Team considers that attempts should be made to standardised requirements across specialty training programs and that full-time research should occur preferably as part of a formal research training program with well defined educational and research outcomes. Mandating a twelve month period of full-time research would seem to be of little value in isolation. As with other aspects of SET, the Team felt that differences between surgical specialties should be educationally defensible and reasons clearly explained.

<table>
<thead>
<tr>
<th>Commendation</th>
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<tbody>
<tr>
<td>H The College’s requirement that all trainees must engage in a research activity.</td>
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</tbody>
</table>

Recommendation

That RACS:

13 Define the educational objectives of the research components of training and review requirements against these objectives.

4.5 Availability of part-time, interrupted and other flexible forms of training

The College’s position on the availability of part-time training is defined in the relevant RACS policy statements. These statements apply to the current surgical training program and have not yet been refined for SET.

At present, Basic and Surgical Trainees are eligible to apply for part-time training or interruption of training upon satisfactory completion of at least one year of basic surgical training in a full-time capacity. Specialist surgical trainees are eligible to apply on commencement of SST. Part-time trainees must still have a training commitment of at least 50 per cent of a full-time trainee in any one calendar year, and must still undertake the same training program components as full-time trainees. Specialist surgical trainees who undertake part-time training or seek to interrupt their training must complete SST within a period no longer than twice the duration of the normal full time program for the relevant specialty.

These policies are based on the traditional and fixed, time-based approach to surgical training. The AMC will wish to monitor the availability of flexible training opportunities with the introduction of

SET, particularly given the proposed emphasis within SET on competency-based training and assessment, and whether this will allow a more customised and flexible training experience.

**Recommendation**

That RACS:

14 Report to the AMC on the impact of SET on the availability of flexible training opportunities.

### 4.6 Transitional arrangements for trainees already in training

The College maintains that the implementation of SET will not significantly impact the duration or structure of training for those trainees currently undertaking specialist surgical training. The College intends to continue the BST program, in parallel with SET, while there are trainees in BST. Current BSTs can remain in BST or withdraw from BST. They will register for PreSET and then apply for SET using the same application process as new non-BST applicants.

The College has indicated that specific priority for selection will not be given to current BSTs, beyond acknowledging that BSTs who have completed the requirements of the BST program will receive recognition for these achievements in the merit-based SET selection process.

**Team’s findings**

Uncertainty about the transitional arrangements has led to significant anxiety amongst current basic surgical trainees. This uncertainty has centred on a lack of clarity around selection criteria for SET, and on whether current BSTs will be offered positions in SET2 in recognition of their prior learning during BST.

The Team understands the challenges involved in merging two distinct phases of training (BST and SST) into the new SET program. Much of the anxiety expressed by current trainees about the transition to SET appears to relate to wide variations in the quantity and accuracy of information available about the SET transition across Australia and New Zealand. This information has gradually become available or been clarified by the College during the course of implementing the SET application. As will be covered in other sections of this report, the Team considered that a revised and comprehensive communication strategy regarding SET would dispel much of this uncertainty.
5.1 **Accreditation standards**

The AMC expects that specialist medical education and training will occur predominantly in and through the work environment with the application of adult learning skills. While much of the learning is self-directed learning, the trainee’s supervisors and trainers will play key roles in the trainee’s education.

5.2 **Educational methods used in the surgical training programs**

The College indicates that as well as competence, the curriculum for surgical training is based on the following interlinking beliefs about knowledge and learning:

- curriculum is a process through which the elements of the teaching and learning are translated into practices.
- adult learning and education with an emphasis on task-orientated, self-directed and experiential approaches.
- the traditional approach to training in surgery where an apprentice learns skills from a master.
- a view of learning, knowledge and ways of knowing that encourages flexibility, critical-reflection and independent research and enhances self-direction, discovery and problem-solving.

The accreditation submission indicates that supervised clinical experiences remains core to the surgical training program. Under SET, greater emphasis will be placed on formalised processes for frequent and direct feedback from supervisors to trainees to assist in the development of their competence.

The supervised clinical experiences will be variously augmented by a number of generic and specialty-specific courses, skills workshops and opportunities for self-directed learning. These are described in section 3 of the report. The specialty specific modules are the means by which teaching and learning are tied back to the curriculum. As noted in the preceding section, these modules articulate the learning objectives and outcomes against which trainees are assessed with a view to progression.

The College intends to increase the use of simulated training environments by developing simulation modalities and skills training to augment the SET program. It has established a Clinical Skills Advisory Group to work with specialty boards, skills laboratories and individual fellows to define and develop clinical skills training as a component of the curriculum of surgical training and as part of the ongoing professional development of fellows. Since it began in 2006, the Group has determined the current use of skills courses in the surgical curriculum and assisted with the introduction of the Fundamentals of Laparoscopic Surgery course in Australia. This course is being piloted in the general surgery training program.

5.3 **Team’s findings**

The work done by RACS in recent years demonstrates the College’s commitment and ability to develop educational resources that support trainees’ learning.

The College intends to move away from a primary reliance on the traditional apprenticeship model towards a more contemporary approach involving apprenticeship, lifelong learning, adult learning and competence. The stated intent to teach judgement via the apprenticeship method would seem an appropriate continued use of the apprenticeship method in a blended learning environment.
The RACS-developed skills courses such as ASSET, CCRISP and EMST have now run for several years, and are well-established, and regularly reviewed. Their contribution to improving trainees’ skills has been tested and their continuation as part of SET is applauded. The College has developed substantial web-based resources to support basic surgical trainees’ self-directed learning including case studies, practice multiple choice questions and discussion forums. At the time of the Team’s review, there had been no discussion about how these might be best used by SET trainees.

The potential for increased use of skills centres and high fidelity simulation was not explored in depth during the accreditation visit, but the Team believes that this is a positive development.

Whilst the documentation on SET is extensive, and considerable work has been done to progress the SET training program, knowledge of the changes entailed in the introduction of SET was limited outside of the College. Despite the centrality of supervised clinical experience in accredited clinical posts, most of the supervisors, trainers, trainees and hospital administrators who the Team met during the site visits were unclear about how the introduction of SET would affect them, if at all.

There exists widespread belief amongst [at least] supervisors, trainees and hospital administrators that teaching to be overseen by supervisors, and delivered by supervisors and other instructors, will remain unchanged following the implementation of SET. Similarly, trainees and supervisors believe that the learning strategies will remain unchanged. However, the stated intention of the College to evolve from an apprenticeship model to a learner-centred model will require different teaching and learning strategies.6

Hospital administrators and supervisors would welcome clarification of how the introduction of SET will affect supervisors’ roles and support requirements. For example, will a PreSET supervisor be required in addition or in place of a BST coordinator in the early days of SET? Supervisors and administrators noted potential challenges, since many supervisors are visiting medical officers whose time in their hospitals is limited.

For these changes to be successful, hospitals will need to recognise the increased time and, potentially, different resources required by trainees, trainers, supervisors and assessors. Accurate estimates of time and other support requirement will inform RACS discussions with the jurisdictions. This will be particularly useful as RACS seeks to fulfil its aim of including standards for training resources and time in its hospital accreditation requirements.

Although the College does have extensive information available, hospitals and jurisdictions do seem to have difficulties finding information relevant to them, and understanding the likely timing of some of the College’s more major changes. The College website was often cited as an example. The College’s communication strategy identifies the website as a key tool, but a common complaint heard by the Team was that it was a challenging ‘maze’ of information. It is recommended that RACS enhance its current communication mechanisms to facilitate rapid and successful communication of key information about SET to all supervisors, trainers, trainees and hospital administrators and jurisdictions.

6 ASSESSMENT OF LEARNING

6.1 AMC accreditation standards on assessment and examination

The AMC accreditation standards on assessment and examination require that:

- The college implements a systematic program of formative and summative assessments that is demonstrated to be reliable and valid.
- The assessment program reflects comprehensively the educational objectives of the training program.
- The college has processes for the early identification of trainees who are under-performing and for determining programs of remedial work.

6.2 Assessment policy and educational principles underpinning the assessment program

An explicit aim of the SET program is to focus on the development and achievement of the articulated surgical competencies as they are acquired rather than on the time spent in training, or the number of patients managed. This presents a particular challenge for assessment.

The approach taken by the College has been to place increasing emphasis on formative assessments procedures and tools, especially those that can be applied in the work place. This permits supervisors and trainers to provide ‘frequent, accurate and directed feedback’ aimed at continuous improvement, and is designed to complement, and in some cases reduce reliance upon, more traditional summative approaches, such as examinations. As is clear from the documentation, however, the latter still play a significant role in the SET program and changes from the current program are evolutionary rather than revolutionary.

With the introduction of SET, the College has been working with the specialty boards to develop a broadly uniform approach to assessment, with greater emphasis on assessment of the articulated competencies. At this stage, most of the work in this area has been directed at SET1. The Team has been provided with documentation outlining each of specialty board’s assessment plans, including the mix of formative and summative approaches. There remains significant heterogeneity between the specialties.

The RACS website also contains information regarding eligibility to present for the Fellowship Examination and eligibility for fellowship. This is presented in a clear and concise manner for all specialty groups; albeit with some variability of the means of presentation.

Commendation

1 The work done by the College and the specialty boards to link clearly the assessment requirements, the nine surgical competencies and the learning objectives.

Recommendation

That RACS

15 Seek congruence of assessment processes between the specialties except when differences can be justified for educational reasons.
6.3 **Formative assessment and work-based assessment**

The increasing role of formative assessment in surgical training is an important change to be introduced by the SET program.

According to the documentation provided to the Team, all specialties currently require mid-term in-training assessments with formative feedback and a formal assessment at the completion of each rotation. The in-training assessment forms for each of the specialties also now reflect that specialty board’s statement of required competence.

To enhance these formative assessment processes, the College is actively encouraging the adoption of a range of work-based assessment tools by the specialties. It is intended that the range of formative assessment tools available to supervisors and trainers across all specialties will now include:

- **Direct Observation of Procedural Skills (DOPS) and Procedural Based Assessments (PBA)** involve the observation of a surgical procedure by a supervisor. They are intended for assessing technical surgical skills.

- **All the specialties require trainees to keep logbooks.** These have been reviewed to reflect the requirements of the SET curricula. The College is finalising a generic logbook for SET1, since trainees in most specialties will be required to complete clinical experiences across a number of specialties.

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

- **Case–Based Discussion (CBD)** involves a trainee and supervisor discussion about a clinical case that is challenging for the trainee.

- **360 degree assessment or Mini Peer Assessment Tool (Mini PAT) or Multi-source Feedback Assessment (MFA)** are used to elicit information about a trainee’s performance from work colleagues other than the supervisors. This can be used to assess competencies related to Collaboration, Health Advocacy and Professionalism and Ethics.

- **In-Training Assessment Forms:** Most specialties have indicated that they intend to use their current in-training assessment forms for SET1. In each clinical rotation, trainees will be assessed on these forms every three months throughout training.

The Team was provided with documentation outlining each specialty’s plans for formative assessment procedures and how these procedures should relate back to the competencies, in particular for SET1.

**Team’s findings**

One of the strengths of SET is the planned expansion of assessment into the workplace; specifically through the use of Mini-CEX and DOPS. The Team commends these plans. As RACS is introducing quite major changes, the Team would encourage the College to research thoroughly the strengths, weaknesses, practicalities and generalisability of Mini-CEX and DOPS in the local hospital setting and to make public its findings. Ideally this would entail a large scale pilot study to inform changes to processes and procedures ultimately used in the final roll out. This would assist in increasing the understanding of supervisors and hospital administrators of the implications of the development.

The College has indicated that it does not intend to use the Mini-CEX and DOPS for summative assessment of trainees. These tools may however be useful in formative assessment. The College’s
own timelines suggest that it will be a number of years before all trainers are trained in the application of these new assessment methods, which raises concerns about adverse effects upon standardisation (across and within training sites), validity and reliability.

The decision not to implement 360 degree assessment until adequate research has been conducted into its potential implementation within each of the nine specialties is appropriate. The number of factors with the potential to contribute to measurement error and the extent of these adverse effects are likely to be considerably greater for 360 degree assessment than for Mini-CEX or DOPS. The AMC will wish the College to report on the problems identified and addressed before it introduces 360 degree assessment for summative purposes.

The Team congratulates the College on including greater formative assessment within the design of SET. This has the potential to lead to improvement in both learning and instruction within surgical training. As part of its efforts to optimise these improvements, the College is encouraged to provide both trainees and trainers with appropriate training in key aspects of effective formative assessment such as the need for feedback and techniques for optimum delivery of feedback.

The College’s accreditation submission indicates that a feature of SET is the emphasis on the early identification and management of under-performing trainees. During each rotation, trainees will be required to meet the required standard of performance, in all of the nine surgical competencies. Unless it is a breach of professional behaviour which could result in immediate dismissal from the program, a trainee who is identified as not meeting those standards will be given a limited number of opportunities to attain the required standard. During that time they will be given clear guidance as to what is required. Failure to attain the required standard in the identified competence area, or poor performance against any other competence criteria could lead to dismissal from the program.

The College’s accreditation submission outlined the processes developed by each specialty to manage underperforming Trainees. The specialty boards intend to continue to use these processes, taking opportunities to improve them. The AMC will look forward to information in annual reports on the College’s success in giving greater emphasis to this area of performance, and on changes made to the management processes.

Commendation

J The College’s commitment to increased formative assessment, which has the potential to improve learning and instruction within surgical training.

Recommendations

That RACS

16 Research thoroughly the strengths, weaknesses, practicalities and generalisability of the Mini-Clinical Evaluation Exercise and Direct Observation of Procedural Skills as assessment tools in the local hospital setting and make public its findings.

17 Report in annual reports to the AMC on the procedures for identification and management of under-performing trainees.

6.4 Summative examinations

Despite the conscious move towards increased use of formative assessment processes, the SET program retains a significant summative examination component. The most important of these are:
The SET1 examination – which build on the current BST examinations. The first examination is a generic Basic Sciences Multiple Choice Examination which tests knowledge in anatomy, physiology and pathology. The second is a practical examination in the format of an Objective Structured Clinical Examination (OSCE) which assesses clinical skills as they relate to RACS Competencies of Medical Expertise, Judgement – Clinical Decision Making, Communication and Professionalism. The specialties of Orthopaedic Surgery, Paediatric Surgery and Plastic and Reconstructive Surgery currently have a specialty specific basic science examination which their trainees are required to pass.

Successful completion of the SET1 exam is generally a prerequisite for progression to SET2. A number of specialties, however, will permit probationary progression to SET2 on the condition that these requirements are completed during the SET2 year. This requirement will continue for trainees selected into those specialties who have already completed the BST examinations.

The Fellowship Examination – all specialties require trainees to complete a final examination leading to the award of fellowship. Conducted by the Court of Examiners, the stated purpose of this exam is ‘to assess the knowledge, clinical skills, judgement and decision making, and professional competencies of candidates, in order to ensure that they are safe and competent to practice as surgeons’. The content and form of the examination is specific to each specialty group. Trainees must have the approval of their specialty board to sit the exam.

In addition to the summative assessments listed above, some individual specialty boards have additional requirement. The specialty of neurosurgery, for example is considering introducing a SET2 examination, the completion of which will be a precondition of progressing to SET3.

Team’s findings

The examination processes of the College will remain largely unchanged.

The College plans not only intensive assessment of technical skills but also assessment of the non-technical competencies that it has identified as comprising the attributes of a surgeon. The Team asks the College to consider the effects of the improved formative and summative assessments on the need for a major summative exit examination in its present form.

As was recommended in the 2002 AMC Accreditation Report, the College has given considerable attention to the standard setting and marking processes for its examinations. In 2005, it introduced a criterion-referenced pass/fail standard for the Basic Sciences Examination. Rasch scaling of the examination is used to analyse the results of the examination and maintain the constancy of the pass standard over time. The model implemented by the College is a modified version of the Angoff Method. The Basic Sciences Examination is externally marked by the Assessment Result Centre at the University of Melbourne.

The College has also introduced a process to analyse the stations included in the Clinical Examination. The analysis performed includes the following:

- The mean performance of candidates at each station is assessed for any major differences between assessment centres.
- Reliability analysis is performed using Cronbach’s alpha to assess the internal consistency of the examination, which in the last four examinations has fallen between 0.55 and 0.65.
- The corrected item total correlation to look at the relationship between each item (station) and the overall score.
The College currently sets the Clinical Examination pass mark at 59.5%. It is reviewing this method and considering the introduction of a requirement to pass a certain number of stations in order to pass overall.

The College intends to continue its evaluation of the Fellowship Examination to monitor the performance of trainees in all the specialties.

With the introduction of SET, the College will need to consider carefully the methods of grouping, linking and equating the various examinations (general and specialty) for the purposes of analyses. When considering analysis of assessment questions, candidate performance and standard setting, the College is encouraged to review the evidence and the appropriateness or otherwise of using item response theory, and to be cautious in its application to current and future assessment analyses.

For there to be rigorous and robust assessment processes the College will need to identify adequate measures of validity and reliability. The implementation of SET provides the opportunity for the College to identify and investigate these measures. Three potential examples are:

- Content validity - SET will allow assessment content to be clearly matched to the new curriculum, thus allowing for accurate identification of content validity.
- Predictive validity - SET will allow performance in the various basic examinations to be compared with performance in workplace based assessment and the final examinations.
- Concurrent validity - SET will allow consideration of the strength of the relationship between performance on one examination and performance on another designed to assess the same underlying abilities.

These are only three of the valuable measures available to the College upon the implementation of SET. Such analyses will provide important information about these new assessment processes that will be of interest to the AMC and to the other medical colleges.

Commendation

K The College’s work on standards setting and review of examination performance.

Recommendations

That RACS:

18 Consider whether in view of the improved in-course assessment the major summative exit examination in its present form could be reviewed.

19 Report on the measures of validity and reliability of assessment processes that it identifies.

6.5 Assessment of overseas-trained specialists

The College has a systematic and appropriately resourced process for assessing whether or not IMGs should be recommended for specialist registration as surgeons in Australia. The process for recognition for New Zealand is similar but not identical and is managed by the College’s New Zealand office to meet Medical Council of New Zealand requirements.

Clear key performance indicators for timeliness of assessment have been developed and the accreditation panel was advised that these timelines are currently being met and, indeed, exceeded.
An initial document screening is used to identify those applicants who should be interviewed. Having five interview sessions per annum has enhanced timeliness. The interviews involve the head of the relevant specialty, a head of another specialty board and a jurisdictional representative.

Timeliness is based on when complete documentation is received and the College notifies all involved of inadequate documentation (applicant, recruitment agency, employer, AMC).

Of those recently interviewed (Feb 2006-June 2007) the outcome is as shown in Figure 4.

<table>
<thead>
<tr>
<th>Nature of Qualification</th>
<th>Requirement</th>
<th>Number</th>
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<tbody>
<tr>
<td>Not comparable with FRACS</td>
<td>-</td>
<td>23</td>
</tr>
<tr>
<td>Partially comparable with FRACS</td>
<td>&gt;24 months supervision/oversight experience(^7) and completion of final exam</td>
<td>Approx 80</td>
</tr>
<tr>
<td>Substantially comparable with FRACS</td>
<td>12 or 24 months supervision/oversight experience(^8)</td>
<td>37</td>
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</table>

IMGs deemed not comparable or screened out at documentary review are eligible to compete for entry to the College training program. If accepted they may be given recognition of prior learning.

The assessment process for IMGs will not be affected by the introduction of the new processes for surgical education and training.

**Recommendation**

*That RACS:*

20 **Continue to publish data on timeliness and outcomes of applications from International Medical Graduates in the College’s Activity Report.**

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\(^7\) The supervision/oversight is to be gained in an approved post under the supervision of a FRACS. The nature of the supervision/oversight will depend in part on the qualification and experience of the IMG.

\(^8\) The supervision/oversight experience is to be gained in an approved post under the supervision of a FRACS. The nature of the supervision/oversight will depend in part on the qualification and experience of the IMG.
7 MONITORING AND EVALUATION

7.1 AMC standards on monitoring and evaluation
The AMC accreditation standards require that the specialist medical college:

• maintains records on the outputs of the training program;
• develops methods to measure outcomes of training and to collect qualitative information on outcomes; and
• has processes for the regular evaluation and review of its training programs, with opportunities for stakeholder input.

7.2 Outputs and outcomes of training
The College publishes annually a detailed and useful report on its activities in education and assessment and on the surgical workforce. Figures provided in the report include details about basic surgical trainees; transitional surgical trainees; and specialist surgical trainees, together with listing of the hospitals accredited for basic surgical training and the hospital posts accredited for specialist surgical training. It also gives information on the numbers of new and active fellows and the outcomes for international medical graduates assessed by the College.

The College’s Surgical Workforce Unit is completing a range of projects to assist the College to measure, evaluate, plan and advocate for a sustainable surgical workforce. The Census of the surgical workforce aims to detail the scope of work of fellows of the College, track changes in working hours and work patterns (including reduced hours/retirement intentions), and gain a more accurate picture of the present and future requirements in regional, rural and remote locations. Results of the census are published through the Surgical News as well as on the College website. Other work of significance has included a pilot Surgical Job Advertisements tracking study; Mapping Access to Surgical Services in Australia, consultations with specialty groups, a range of reports and presentations that examine the rural surgical workforce, the NZ Surgical Needs Analysis Project and projection modelling of surgical workforce and training requirements to 2016.

Team’s findings
The College has an impressive approach to monitoring and reporting on the numbers and distribution of trainees and their progress. In particular, the College has developed significantly its databases to identify trainees, to track their progress, and to provide valuable aggregate data about the surgical education programs.

The annual activities report, which the College initially published to meet ACCC reporting requirements, is a very useful summary. The Team commends the College’s decision to continue this publication despite its decision not to seek re-authorisation by the ACCC. These data could form the basis for an analysis of the impact of the SET program.

The work of the College’s Surgical Workforce Unit is potentially valuable for jurisdictional workforce planning and we commend the College’s plans to continue to work with the jurisdictions in this important area.

7.3 Evaluation and review of training programs
The 2002 AMC Accreditation Report on RACS programs acknowledged that many of the educational initiatives implemented by RACS were either still being developed or relatively new and therefore, program evaluation systems had not been planned. That Report provided a series of recommendations
on building such systems, emphasising the need for RACS to prioritise the aspects of its educational programs for which it required program evaluation feedback, and to ensure proper evaluation systems were fully developed and functional.

The College’s 2007 accreditation submissions describe processes for annual review of components of the training programs through College committees. For basic surgical training, this has been a role of the Board of Basic Surgical Training and the committees which manage the specific courses (ASSET, CCRISP etc). For specialist training, the various specialty boards take responsibility for review of their selection, training and assessments processes. The College’s accreditation submission indicated that these reviews would continue.

**Team’s findings**

Program evaluation will be an important part of introduction of SET. Discussions during the Team’s visit suggested that the plans for evaluation were not yet well developed. This was emphasised by the statement by all the specialty boards that no changes were planned to their current evaluation processes.

The College’s educational staff indicated that highest priority would be the evaluation of the selection process, seeking feedback from the specialty societies. It will be important for RACS also to seek feedback on the process from applicants and other important stakeholders such as the hospitals.

The College accreditation submission indicates that work-based competency assessments will be monitored and evaluated in terms of their effectiveness and the response of supervisors and trainees to the additional assessment processes.

There are a number of other proposed changes which could be priority areas for evaluation, and the Team would urge the College to develop its evaluation plan as a matter of priority.

Plans for trainee and supervisor evaluation of SET were discussed in general terms only, with the College indicating that current processes will be reviewed to identify how they can be improved. The AMC standards for accreditation of specialist training programs include those for review of training programs and the AMC will look forward to information about this is in the College’s annual report.

The AMC expects colleges to seek feedback from a number of stakeholders such as hospital administrators, related medical specialties and consumers on the outputs of training. These processes seem to be underdeveloped.

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<td>L The College’s annual Activities Report.</td>
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**Recommendations**

*That RACS:*

21 Develop and report to the AMC on its plans to evaluate the introduction of the SET program.

22 Introduce procedures to collect feedback on the training program from external stakeholders such as health administrators and health consumer groups.

23 Report in annual reports to the AMC on plans for trainee and supervisor evaluation of SET.*
8 ISSUES RELATING TO TRAINEES

8.1 AMC standards
The AMC accreditation standards require that the specialist medical college:

- selects trainees into training programs based on the principles in the 1998 report, *Trainee Selection in Australian Medical Colleges* by the Medical Training Review Panel
- has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training
- has mechanisms to inform trainees about the activities of its decision-making committees, in addition to communication by the trainee organisation or trainee representatives
- provides clear and easily accessible information to prospective and existing trainees about the training program, costs and requirements, and any proposed changes.

8.2 Admission policy and selection
Selection into the SET program is administered by each of the nine specialty boards. The Boards may undertake this function through the specialist societies which have developed Memoranda of Understanding with the College. The boards’ standards for selection must conform to those of the Australian and New Zealand Medical Councils and to the basic Brennan principles for selection. Selection is carried out nationally or bi-nationally, depending on the specialty. The number of trainees selected into the SET program is determined by the number of accredited specialist surgical training places (i.e. SET2+) in Australia and New Zealand, and the numbers of trainees exiting each program. Applicants for training will include doctors in prevocational training, basic surgical trainees, those who have completed or wish to transfer from other vocational training programs and international medical graduates. Applicants apply to one or more programs and there is no limit to the number of reapplications.

The College has provided the Team with documentation describing the steps in the selection process, eligibility criteria generic to all specialties, eligibility criteria specific to specialties and the mechanism for providing feedback to unsuccessful applicants.

Aspiring surgical candidates are invited to pay a fee for preparation for SET (PreSET). This provides registration with the College enabling access to publications and information. Before entering SET, doctors are expected to complete a series of clinical placements, which varies between specialties. Existing BSTs can apply to the SET program, or withdraw and register in PreSET. Regardless, the College is committed to acknowledging prior learning in determining the SET level each trainee will enter.

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9 For the College these have been broadly interpreted as:
1. Selection processes must be merit based, free of bias and, to the greatest possible extent, quantifiable
2. Selection processes must be compliant with relevant Australian and New Zealand laws and the principles of natural justice and procedural fairness
3. Selection processes must be open to external scrutiny and conducted in an accountable manner using documented processes
4. Selection processes must be conducted on a national or bi-national basis in Australia and New Zealand
5. The opportunity to apply for selection must be publicised in a manner which creates awareness of opportunity for all eligible applicants
6. Criteria in all of the tools must be related to objectives of the training program and the desired attributes of graduates.
Each specialty board designs its own pre-selection requirements and selection tools, under the auspices of the College Board of Specialist Surgical Training.

Selection of surgical trainees directly into a specific specialty training program is one of the major changes associated with the SET program. Applicants can in practice apply in their second postgraduate year. The College is keen to see entrance to training at a younger age and hopes that medical students in their last one to two years of training will be preparing for a surgical career.

Team’s finding
The new online selection process for SET was introduced this year. Many BST trainees applied for several training schemes.

There are significant differences between the specialty boards in their selection processes such as the eligibility requirements, online application forms, number of referees required and weighting of selection tools. The boards are committed to excellence in education and are proud of and wish to preserve their individuality, but this can manifest itself as differences in processes that may not be justified. While these differences often offer opportunities to test new processes and may be very appropriate, many do not appear to be based on evidence. These differences have caused confusion for SET applicants, and the Team urges the College to continue to seek where possible sensible common standards for selection and training across the surgical specialties. Where differences continue the reasons for them should be defensible and clearly expressed.

There are also differences in the quality of the feedback available to unsuccessful applicants following the selection process. Some specialties provide very specific information on the applicants’ ranking and the ways to improve their application, which could guide the development of a standard process for the College.

The College indicates that the number of trainees selected into each specialty each year has traditionally been based on the number of posts vacated in that specialty at the conclusion of the current year. The ‘bottleneck’ that has existed at the point of transition from basic to specialist surgical training may in the future be displaced to the PreSET stage. Under the new program, medical graduates interested in surgery can register with the College, and receive College advice on the educational and training requirements for gaining selection into the SET program. Some hospitals and jurisdictions are already providing more resources for PreSET medical officers as they see recruitment advantages in being seen as ‘surgical trainee friendly’.

The SET program will allow application to be made from postgraduate year 2 to commence surgical training in postgraduate year 3. The College states that it is not assumed that all applicants will apply from that level of training. Some concern was expressed to the Team about young doctors choosing a specific surgical training stream so early. Others suggested, however, that only a small minority of applicants would be selected early in their postgraduate careers, as building up the work and life experiences that were needed for selection would take time. The AMC will follow this issue with interest.

There is considerable uncertainty about the number and distribution of available SET1 and 2 positions both in Australia and New Zealand. Most hospitals and jurisdictions understand that the numbers will be significantly fewer than the numbers entering basic surgical training, leading to fears of workforce shortage. The College points out, however, that in the future the workforce roles previously carried out by basic surgical trainees will be undertaken by doctors waiting to enter SET (PreSET medical officers), doctors in prevocational or other vocational training programs or career medical officers. The Team has made a recommendation for a detailed report to the AMC on the selection outcomes.
Some jurisdictions expressed concerns that the lower numbers in SET1 compared with those in the BST would lead to falls in the output of qualified surgeons. It is clear that this is not so. The numbers of qualified surgeons leaving the training program will not fall and may be somewhat higher.

The jurisdictions and the College wish to increase output of well-trained surgeons. Several jurisdictions are developing workforce planning exercises and are eager for the College’s assistance. The AMC would encourage cooperation, including an appreciation by both parties that the educational integrity of the training programs and the need to fund more training places are important issues.

Recommendations

That RACS:

24 Report to the AMC on the evolution of the selection process, taking account of feedback from the specialty societies, the applicants and other stakeholders.

25 Continue to collaborate with the jurisdictions to increase the output of well-trained surgeons.

8.3 Trainee participation in College governance

The College has recently facilitated and resourced the formation of an internal trainee representative structure, the RACS Trainee Association (RACSTA). The College states that RACSTA was established to better represent trainees’ interests within the institution and to fully understand trainees’ perspectives on the surgical profession. RACSTA is now established as a broadly representative trainee association, comprising geographic, basic and specialty surgical trainee representatives who are elected by the trainees, and form a bi-national committee and executive. The current committee’s two-year term began in January 2007.

Trainees are now represented, through RACSTA-nominees, on all education-related Boards and committees throughout the College. Trainee representatives reported to the Team that their views and comments were regularly sought and seriously considered at these meetings. The chair of RACSTA attends RACS Council meetings, although their status is one of an observer without voting rights.

Regional branches of RACSTA have also been formed with regional representatives responsible for coordinating representational activities at a local level. Regional RACSTA activity is patchy and dependent upon the enthusiasm and commitment of regional trainee representatives and local trainees. Certain regions have highly active RACSTA branches, with one state (Western Australia) having a dedicated website for publication of its activities. Regional RACSTA meetings are convened and publicised by regional representatives with variable levels of regional secretariat assistance to arrange and publicise meetings.

The Team acknowledges the inherent challenges of mobilising regional interest in RACSTA activities, which is often dependent upon a small number of vocal enthusiasts. Nevertheless, the activity and effectiveness of regional RACSTA committees could be boosted through improved resources and dedicated secretariat support for the operational/organizational aspects of regional activity.

The Team commends the College on the substantial improvements that have occurred in respect to trainee participation in College governance since the last AMC accreditation, and acknowledges the support and status afforded to trainee representatives on the various College committees. A further step favoured by the Team would be consideration of creating a voting position on the Council.

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10 RACS AMC submission p149
8.4 Communication with trainees

The College has made significant attempts in recent years to improve formal and informal communications with trainees in Australian and New Zealand. This was echoed by many trainees interviewed by the Team, who reported a noticeable cultural change within the College, citing recent initiatives such as broadcast emails from the College President and the formation of RACSTA. Trainee issues are now promoted through a regular, albeit short, segment within Surgical News, published monthly. This trainee column appears to be widely read and appreciated by trainees in both Australia and New Zealand.

RACSTA has been a significant and positive initiative for trainee engagement within the College, and with further expansion of regional networks, there is great potential for the development of stronger communication networks. Much of the responsibility for communication at a regional level is left in the hands of individual trainee representatives who coordinate meetings themselves and arrange broadcast email communications. The Team found that trainee awareness of the specifics of RACSTA activities varied widely and was often limited, particularly away from those hospitals where RACSTA representatives were based. Furthermore, many trainees appeared content to leave trainee representation in the hands of those nominated representatives, and still did not see RACSTA as an avenue for raising concerns or queries about their training experiences.

This no doubt reflects, to some extent, the traditional challenges of encouraging trainees who are already working long hours to become involved in College affairs, and breaking the perceived hierarchical barriers that often deter trainee participation. There remain concerns amongst trainees, however, about the implications of ‘making a fuss’. Hence, many trainees appear disinclined to contact the College to provide feedback or participate in trainee representation. The AMC will be keen to follow progress over time of the current initiatives to engage with the trainee community.

The College has devoted considerable time and resources to communicating with trainees and potential trainees about SET, via meetings with senior staff, the SET Program booklet, and the website. Despite this, only a minority of trainees considered they had sufficient information about the SET program although some appeared better informed than their supervisors or trainers. There was a general perception that the information was not adequate, complete or reliable. Common matters of concern for trainees were the difficulties in accessing timely and accurate information on the SET eligibility criteria and the transitional arrangements for BSTs.

The high number of telephone calls to the College from trainees and potential trainees seeking clarification on the SET admission process is perhaps testimony to the confusion experienced by many potential applicants. This uncertainty was further fuelled by inconsistent and evolving responses to trainee email and telephone enquiries, and a website which many trainees found difficult to navigate to identify newly updated information.

Trainees and SET applicants can lodge enquiries regarding SET through dual email channels. There is a ‘SET enquiries’ email address monitored by the secretariat, and a regional RACSTA representative email address, available on the RACS website. The Team noted with interest the existence and relative complexity of the ‘communication flowchart’ for trainee issues available on the RACSTA
website\textsuperscript{11}, and wondered how this aided trainee perceptions of the ease of communication with the College.

The College should also consider how trainees can be engaged as part of a more sophisticated communication strategy about the SET program. A simple improvement would be to expand the trainee page within the Surgical News, possibly with the help of College staff, who may be able to assist with collating and drafting trainee contributions and opinions.

Regional RACSTA representatives should also receive additional overt administrative support to strengthen local communication networks, through regular regional email broadcasts and hospital-based regional RACSTA meetings.

The Team believes that improvements in the design of the website, which is an integral tool in communicating information on the SET program as it evolves, would assist in communication to trainees. The Team would encourage the College to work with RACSTA to improve the website.

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\textbf{Commendation} \\

N & The improvements made by the College to its processes for communicating with trainees. \\

\textbf{Recommendations} \\

\textit{That RACS:} \\

26 & Consider how trainees can be engaged as part of a more sophisticated communication strategy regarding the SET program. \\
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\textsuperscript{11} RACSTA Communication Flow Chart, RACS website, accessed August 2007: http://www.surgeons.org/AM/Template.cfm?Section=Committee_Contacts1&Template=/CM/HTMLDisplay.cfm&ContentID=13060
9 SUPERVISION

9.1 AMC accreditation standards on supervision

The AMC Accreditation Standards require the specialist medical college to have processes for selecting and training supervisors, trainers and assessors. In addition, the AMC requires the college to have processes for ensuring that trainees receive regular feedback from supervisors and trainers, and for obtaining confidential reports from trainees on the quality of their supervision, training and clinical experience.

The AMC also encourages the college to assist all trainees in identifying a suitable mentor who is not, and is highly unlikely ever to be, a supervisor, assessor or trainer for the trainee.

9.2 Supervisors and trainers

In each hospital which has a basic surgical training program, the Royal Australasian College of Surgeon’s Board of Basic Surgical Training appoints a Hospital Supervisor of basic surgical training on the nomination of the hospital. The College provides a detailed information booklet for these supervisors, which include a statement of the duties of the supervisor as well as general information on the surgical training program.

All hospitals with accredited specialist surgical training programs have hospital supervisors of surgical training and specialty supervisors of training who oversee trainee progress. The accredited training hospitals appoint the supervisors, and this is subsequently approved by the relevant specialty board and College.

The College states that it expects supervisors will be fellows of RACS and members of the surgical staff of the hospital. Supervisors hold office for an initial three-year period and can be re-appointed up to a maximum period of six years, although the College will consider extending this period in special circumstances, for example, in the smaller specialties or hospitals.

The College’s statement of the duties of a supervisor includes the following:

- to advise specialist surgical trainees on all aspects of surgical training
- to ensure that specialist surgical trainees are appropriately registered
- to monitor logbook entries by regular three-monthly inspection
- to arrange regular meetings with surgeons and to discuss programs and progress of individual trainees
- to monitor, report (on a three-monthly basis) and manage trainee performance during specialist surgical training
- to provide reports to enable the specialty board to make recommendations regarding trainee eligibility to sit the Fellowship Examination and regarding progress and completeness of training
- to be a member of the regional subcommittee of the specialty board
- to be present at the College inspection of their specialty program
- to participate in the selection of specialist surgical trainees.

The College’s information for supervisors of specialist surgical trainees is supplemented by detailed information for each of the nine specialties.

The College offers three educational skills courses for supervisors and trainers:

- The Surgical Teachers Course is a two and a half day workshop which aims to enhance the educational skills of surgeons responsible for teaching, mentoring and assessment of trainees and
others. It consists of four major modules: adult learning, teaching skills, feedback and assessment, and leadership and change.

- The advanced Surgeons as Educators Course is a five-day course designed to develop further the educational skills of surgeons who have participated in the Surgical Teachers Course. This course has a broader audience than just supervisors and trainers - it is also targeted at fellows who have senior governance roles in the College within the education/professional development areas. The four major modules of the course are: curriculum development, teaching skills, performance – program evaluation, and education administration and management.

- The SATSET course, Assessment and Management of Trainees, is a three-hour course designed to help supervisors and trainers effectively use some of the new workplace assessment tools that have been developed as part of SET. Initially the course will focus on a mini-clinical examination exercise (Mini-CEX) and Direct Observed Procedural Skills (DOPS). Supervisors and trainers will be able to explore strategies to improve their management of trainees, especially those who are under performing. There will also be an opportunity for supervisors and trainers to gain more insight into College training policies, supervisor and trainer responsibilities, the appeals process and support provided by the College.

The surgical supervisor and the regional committee of the relevant specialty board are responsible for the in-training assessment of specialist surgical trainees. The College’s website provides guidance on the implementation of the three-monthly assessment requirements. As noted in Section 6 of this report, the College intends to include a greater emphasis on formative assessment within the design of SET, as well as new work-based assessment tools.

Team’s findings

The 2002 AMC Accreditation Report commended the commitment of supervisors to their trainees and to the hospitals in which they work. The 2007 Team was equally impressed by their commitment.

One benefit of the implementation of SET is the opportunity for the College, societies and specialties to renew support to supervisors. RACS is to be commended on recognising this opportunity.

Many supervisors met by the Team did not feel well informed about SET. They expressed a high level of uncertainty about their capacity to undertake the additional in-training assessment requirements of SET and of the procedures that would be assessed. Some were unaware that other trainers could also conduct these assessments. Many commented on the very rapid implementation of SET and limited supervisor training. An important reason to communicate information about SET to supervisors is so that they will be seen by trainees as knowledgeable about the training program that they supervise. This will facilitate an appropriate supervisor-trainee relationship as well as provide support from RACS to the supervisor.

The College acknowledges that there is considerable work required to ensure all supervisors are familiar with these new tools, and intends to introduce them for SET1 only in 2008. It plans to use three monthly Mini-CEX for SET1. It hopes over time to increase the number of assessment tools and relative frequency of their use.

The supervisor workshops are key strategies for the successful implementation of SET. RACS has run its first workshop and more are planned for 2007. In discussion with the Team, RACS officers suggested that the College would aim to train at least one supervisor/trainer in each group/centre in the short term. As there are more than 1,100 specialist surgical trainees, it estimates that there may well be thousands of supervisors and trainers.

Participation in the supervisor workshops will need to be expanded to include all those who will assess trainees and/or administer a Mini-CEX or DOPS, i.e. supervisors and other trainers. It will be
important for RACS to evaluate the extent to which the three-hour workshops are capable of effectively teaching the large number of desirable educational outcomes. RACS may need to consider additional workshops or strategies to achieve the desirable objectives.

The College intends to consider hospital support for supervisory time as part of its accreditation of training sites. The Team noted that in some specialties, particularly orthopaedics, the average number of weekly sessions in public hospitals in Australia is low. This may make it increasingly difficult for supervisory requirements to be met.

During the assessment, the Team and College officers discussed at the length the possibility of introducing a process for trainees to evaluate the quality of their supervision. The College is seeking external advice on this matter, and acknowledges that whatever process is developed must be non-threatening to the trainees.

9.3 Mentors

RACS provides a Facilitated Personal Mentoring Scheme for all trainees in BST which provides an opportunity to have a personal mentor who provides professional guidance, general support and encouragement to the trainee. Facilitated mentoring was chosen as the model most likely to meet the needs of trainees who had not developed a spontaneous mentoring relationship. The Team was uncertain if this would be extended to SET trainees.

As part of the development of the Scheme, the College has appointed a coordinator to facilitate the establishment and maintenance of the relationships, provide advice and assistance to trainees and mentors relating to the scheme and to promote the scheme and recruit mentors. The development of the College website will also include a revised mentoring section.

RACS has also developed a Mentoring in the Workplace workshop which is designed for those involved in leadership roles and/or facilitation of learning in the workplace. Using a mix of lectures, reflective exercises and facilitated small group discussion, participants consider the skills and attributes required to be an effective mentor and to assess the commitment required for mentoring. In addition the workshop assists participants to prepare for the mentoring relationship by identifying strategies to resolve difficult situations.

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<td>O The commitment of surgical supervisors and trainers to their trainees.</td>
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<td>P RACS’ commitment to renewing its support for supervisors.</td>
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**Recommendations**

**That RACS:**

27 Report in annual reports to the AMC on:

- changes in the workload of supervisors after the introduction of SET
- the introduction of training for supervisors and trainers in the new work-based assessment methods
- progress in developing a process for trainee evaluation of their supervision.

28 Increase communication with supervisors and trainers about SET.

29 Consider making the SATSET course, Assessment and Management of Trainees, mandatory for supervisors and trainers.
10 ENVIRONMENT FOR TEACHING AND LEARNING

10.1 The AMC standards

The AMC accreditation standards on assessment and examination require that:

- The college specifies the clinical experience, infrastructure, educational programs and support required of an accredited training institution/training position.
- The college implements clear processes to determine whether training institutions and training positions meet these requirements.
- The college’s accreditation standards are publicly available.

10.2 RACS criteria for accreditation of hospitals and training posts

The College has recently revised its standards and processes for accreditation of hospitals and training posts. This followed a review of the accreditation program that was conducted in 2005 as a requirement of the authorisation granted by the ACCC.

The new standards and processes were produced following extensive consultations with the various College Boards, the specialty societies, the jurisdictions and other stakeholders. They also address a number of the recommendations contained in the 2002 AMC Accreditation Report.

The guiding principle of the accreditation process is ‘to ensure that education and training sites provide learning environments which facilitate the training of safe and competent surgeons’ through ‘objective assessment of training sites carried out by a professional team which includes surgeons and jurisdictional representative’.

There are seven standards that are generic across specialties. Specialty specific standards and criteria can be applied over and above these. The seven generic standards, along with their rationale, are:

1. Education facilities and systems required – All trainees must have access to the appropriate educational facilities and systems required to undertake training.
2. Quality of education, training and learning – Trainees will have opportunities to participate in a range of desirable activities, the focus of which is inclusive of their educational requirements.
3. Surgical supervisors and staff – Program managed by appropriate and accessible supervisor supported by the institution and committed surgeons, delivering regular education, training, assessment and feedback.
4. Support services for trainees – Hospitals and their networks committed to the education, training, learning and wellbeing of trainees who in turn acknowledge their professional responsibilities.
5. Clinical load and theatre sessions – Trainees must have access to a range and volume of clinical and operative experience which will enable them to acquire the competencies required to be a surgeon.
6. Equipment and clinical support services – A hospital must have the facilities, equipment and clinical support services required to manage surgical cases in a particular specialty.
7. Clinical governance, quality and safety – A hospital involved in surgical training must be fully accredited and have the governance structure to deliver and monitor safe surgical practices.

The College and the specialty societies have produced documentation that outlines the standards, the accreditation criteria, information on how each of the criteria is assessed, and the minimum
requirements to be satisfied. The College provides potential accreditation applicants with a template to assist with the application process.

Additional specialty specific standards and criteria are readily available from the respective specialty society websites.

The process for accrediting hospitals and training posts is shared by the College and the specialty societies. In a number of the specialties, this responsibility is fully delegated to the relevant specialty society.

The steps in the accreditation process, as described in the College’s documentation cover:

- the application, its handling and initial assessment
- the accreditation team visits, including the composition of team, and its expected plan of meetings
- the production of an accreditation report with mechanisms for feedback from the applicant organisation
- the decision making process, remedial measures and avenues for appeals.

The documentation identified sources of additional information and resources for each of the major steps as well as the responsible agent within the College or specialty society.

10.3 Accreditation of SET1 positions

SET1 Trainees will complete clinical placements in hospitals accredited for training. Specialty Boards will allocate Trainees to accredited hospitals in the same way as they now do in allocating SST Trainees to accredited posts. Within the hospital, the trainee will nominate their preferred rotations, and the hospitals will arrange the rotations in consultation with the College when necessary. This follows the process used for BSTs.

Taking into account the difference between jurisdictions, specialties defined their expectations for SET1 rotations with some flexibility so that SET1 positions can be no less than 10 weeks and no more than 26 weeks in duration.

Under the SET program, existing SST accredited posts will be designated as SET2+ posts, and will be allocated to trainees who have completed their first year of surgical training.

At the time of the Team’s review, the College had written to hospitals currently accredited for SST inviting them to express interest in having SET1 positions. The letter identified which of the surgical specialties already had accredited posts in the hospital. In their response, hospitals were asked to indicate which of those specialties they wished to be considered for, and the number of positions in each specialty they were able to offer. The specialty boards then conducted a paper-based accreditation process for SET1 training posts for 2008. SET1 positions will be formally accredited as part of each hospital’s five-year accreditation cycle.

10.4 Team’s findings

The Team commends the College and the specialty societies on the progress that it has made in developing explicit accreditation standards and criteria and a clear accreditation process.

The seven generic standards for hospital accreditation is a laudable development. Nevertheless, hospitals still undertake separate accreditations by each surgical specialty. Whilst the Team recognises the specific requirements of each of the specialty training programs, it encourages the College and the
specialty societies to look for opportunities to streamline and rationalise the accreditation program further.

The College is beginning to address important areas such as assessment of trainees’ experience of continuity of care from presentation to a clinic, hospital admission, surgery and postoperative management and follow up of the patient in the clinic. This may well involve trainees following patients who move between private and public facilities as part of their therapeutic journey. The Team commends this and waits with interest the outcome of these deliberations.

During the site visits, the Team encountered disquiet from hospital managers about the process for accrediting hospital training posts for the introduction of SET. Some of this related simply to the timeframe. As of July 2007, most hospitals still did not know how many SET1 positions they would be receiving for 2008, although the Team understood this information would be available in a matter of weeks.

Of greater concern to a number of hospitals was the possibility of not receiving accreditation at all for the SET program where they were previously accredited for BST posts. This is especially true for hospitals which are currently accredited for BST but have no SST accredited posts. In some cases this problem is expected to be mitigated by hospital networks. Rural and regional hospitals have reported concerns about loss of BST accreditation on medical staffing. The Team was assured on several site visits that SET trainees will rotate to such hospitals.

Commendations

Q  The development of explicit accreditation standards and criteria, and a clear accreditation process.

R  The early discussions within the College about ensuring that trainees experience continuity of care of the surgical patient.
11 PROFESSIONAL DEVELOPMENT PROGRAMS

11.1 AMC standards concerning continuing professional development programs

The AMC requires that specialist medical colleges have continuing professional development programs to assist their members to maintain their knowledge, skills and performance, so that they can deliver adequate and safe medical care. It also requires that colleges monitor specialists’ participation in continuing professional development programs in all areas in which they practise and have processes to counsel fellows who do not participate. Colleges are also expected to have processes in place for retraining and remediation of fellows who are under performing.

The New South Wales Medical Board requires specialists to participate in continuing professional development programs at least to the minimum level of the requirements of the relevant college and to report to the Board annually on these activities. In New Zealand satisfactory participation in a recognised CPD program by all medical practitioners is compulsory. Colleges must undertake random audit of the CPD returns of their fellows.

11.2 Description of RACS Continuing Professional Development Program

The RACS Board of Professional Development and Standards sets policy and reviews the CPD program, and implements standards relating to professional development and maintenance of competence.

All fellows who are in active practice are required to participate in the CPD Program. The current three-year cycle commenced in January 2007 and will conclude in December 2009.

The College has defined eight categories of continuing professional development activities:

- Category One: Surgical Audit and Peer Review
- Category Two: Hospital Credentialing
- Category Three: Clinical Governance and Evaluation of Patient Care
- Category Four: Maintenance of Clinical Knowledge and Skills
- Category Five: Teaching and Examination
- Category Six: Research and Publication
- Category Seven: Other Professional Development
- Category Eight: Medico Legal Activities

The College has incorporated the nine RACS competencies, described in section 3 into its CPD program. It offers a number of workshops and courses that address mainly non-technical competencies.

The CPD requirements differ according to type of practice and the College’s CPD Programme Information Manual describes eight different types of practice (e.g. operative practice in hospitals or day surgery units, operative procedures in rooms, clinical consulting (non-operative), surgical assisting) and the requirements for each type. Requirements are the same for full time and part time surgeons.

All surgeons in operative practice are expected to be involved in audit, peer review and quality assurance activities. The College provides support for auditing activities. Fellows who are involved in activities that are not covered by the defined types of practice or who have difficulty meeting requirements may apply to complete a CPD portfolio. Approval to participate in an alternative CPD program may also be sought.
A similar program is also available to surgeons who are non-fellows. This is known as the Maintenance of Professional Standards (MOPS) Program.

The CPD program is regularly reviewed including surveying fellows about content and to identify barriers to participation and how the College can better support fellows and also with reference to current literature on the effectiveness of various professional development activities. Participation and compliance rates are high. In 2005, 90 per cent of fellows participated and of these 98 per cent complied with the annual requirements. Although recording of CPD can be done online uptake of this is currently low.

Those who do not participate in the annual cycle receive up to three reminder letters, the third from the College President. Specialty society representatives on the Professional Development and Standards Board are asked to follow up on non-participants and those who are non-compliant at the time of the second reminder letter.

The College randomly selects 2.5 per cent of fellows to audit annual participation. Those who are unable to verify their CPD are not eligible for the annual statement of participation or the triennial certificate.

Information on the recertification status of fellows is available to the public on enquiry to the College. From late 2007 the ‘Find a Surgeon’ facility on the College website will only identify surgeons who are meeting their triennial CPD requirements.

The College has established a structure to retrain fellows though this can be dependent on the availability of suitable public hospital positions. Retraining tends to focus on technical competency though the College acknowledged to the Team that non-technical competencies are also sometimes an issue. The College could consider incorporating SET in-training assessment tools in its retraining program.

The Team was advised that the College has been advocating to medical boards and hospitals/jurisdictions that CPD to be mandatory for registration and credentialing.

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