DRAFT DETERMINATION

Application for Authorisation

lodged by

The Royal Australasian College of Surgeons

in respect of

The selection, training and examining of surgeons in specialities in which the College conducts training

The College’s role in accrediting hospitals for basic surgical training and hospital posts for advanced surgical training

and

The College’s role in assessing overseas-trained doctors

Date: 6 February 2003

Authorisation No: A90765
Public Register: C2000/1776

Commissioners: Fels
                  Bhojani
                  Jones
                  Martin
                  McNeill
Executive Summary

On 28 November 2000, the Royal Australasian College of Surgeons (the College) lodged application for authorisation\(^1\) A90765 with the Australian Competition and Consumer Commission (the Commission). The College lodged a submission in support of its application for authorisation with the Commission on 30 March 2001, at which time the Commission’s assessment process commenced. This submission is outlined in Attachment A to this summary.

The College

The College is a private professional association established in 1927 and incorporated in 1930 in Melbourne, Victoria. Approximately ninety per cent of Australian surgeons are College Fellows.

Origins of the College’s application

The College’s application followed a two-year investigation by the Commission into allegations that the College’s processes restrict entry to advanced medical training in breach of the Act. The Commission’s investigation focused on the College’s role in deciding how many trainees received advanced training in orthopaedic surgery and how it assesses overseas-trained surgeons.

In September 2000, the Commission informed the College that it considered that this conduct may breach the Act. In response, the College informed the Commission on 9 October 2000, that it intended to apply for authorisation for its training and assessment processes. On 19 October 2000, the Commission stated that it would suspend its investigation while the application was being genuinely pursued.

The College’s application

The College has sought authorisation for its primary functions which are as follows:

- selecting, training and examining trainees in basic surgical training and in each of the nine surgical sub specialities in which advanced surgical training is offered;
- accrediting hospitals as being suitable for basic surgical training if they meet standards set by the College;
- accrediting individual hospital posts as being suitable for advanced surgical training if they meet standards set by the College; and

\(^1\) The ACCC has the function, through the authorisation process, of adjudicating on certain anti-competitive practices that would otherwise breach the *Trade Practices Act 1974*. Authorisation provides immunity from court action, and is granted where the ACCC is satisfied that the practice delivers offsetting public benefits. Applications for authorisation are considered on a case by case basis and involve broad public consultation with interested parties. The onus is on the applicant to demonstrate that there is a public benefit arising from the conduct and that the public benefit outweighs any public detriment.
• assessing the qualifications, training and experience of overseas-trained practitioners who wish to work as surgeons in Australia to determine whether they are equivalent to Australian-trained surgeons.²

Surgical training and examination

Medical graduates wishing to become surgeons must complete two years of basic surgical training and between four and six years of advanced surgical training depending on the specialty. The College administers these training programs and College Fellows do the actual teaching.

Broadly, surgical trainees are apprenticed to College Fellows. Over the course of basic and advanced surgical training, the scale and complexity of the surgical tasks trainees perform is increased so that, by the time they have completed training, they are ready to undertake all the operations expected of a surgeon in a particular specialty without supervision.

In addition, trainees must pass a ‘Part 1’ exam at the end of basic surgical training and a ‘Part 2’ exam at the end of advanced surgical training. The College sets, administers and marks these exams.

Selection of trainees

Prospective trainees must apply to the College to obtain a position in basic surgical training and apply again (2-4 years later) for a place in advanced surgical training. The College determines the selection process (assessment based on curriculum vitae, interview performance and referees’ reports), sets the selection criteria and ranks applicants against these criteria. It also determines the ‘cut-off’ standard below which applicants are not eligible to enter training.

Accrediting hospitals and hospital posts

Basic surgical training may only take place in hospital posts in hospitals accredited by the College. Advanced surgical training may only take place in hospital posts accredited by the College. The College sets the criteria for accrediting hospitals for basic training and hospital posts for advanced training. It also appoints teams of College Fellows to ascertain whether hospitals/hospital posts meet the relevant criteria and makes the final decision about whether to grant accreditation.

Assessing overseas-trained surgeons

Doctors, including overseas-trained surgeons, may only practise in Australia if they are registered by one of the state or territory medical boards. Commonwealth, state and territory governments have established a system under which the College assesses whether overseas-trained surgeons wishing to practise in Australia are equivalent to Australian-trained surgeons. The College appoints assessment teams of College Fellows to assess individual applicants. The College then forwards a recommendation to the relevant medical board, which is almost invariably accepted. The recommendation will usually be one of the following:

² The College conducts advanced surgical training, and assesses overseas-trained surgeons, in the following specialities: cardiothoracic surgery (heart and chest), general surgery, neurosurgery (nervous system, including brain), orthopaedic surgery (skeletal system), paediatric surgery, plastic and reconstructive surgery, otolaryngology (ear, nose and throat), vascular surgery (blood vessels) and urology (urological tract).
that the applicant be required to complete basic and/or advanced surgical training in Australia before being registered; or

that the applicant be required to complete a period of supervised assessment in a hospital position before being registered.

**Commission assessment process**

The Commission conducted an extensive public consultation process to assist its consideration of the College’s application. In particular, the Commission actively sought the views of state and territory government health ministers and agencies, which are the largest employers of surgeons in Australia.

Submissions were ultimately received from nearly all health ministers, largely in the second half of 2002. These are outlined in Attachment B to this summary. Broadly, governments support authorisation being granted provided concerns held by nearly all of them regarding transparency, accountability, fairness and consistency of the College’s processes are addressed.

Other submissions were received from, among others, state and territory medical registration boards, specialist medical colleges, industry associations, consumer groups, private health insurance funds and university medical faculties.

In total, the Commission received over 80 substantive submissions in relation to the College’s application. An overview of all public submissions is provided in Chapter 11 of this draft determination.

**Commission evaluation**

**Public benefit**

The Commission is satisfied that the College’s training and assessment processes generate a significant public benefit by ensuring that surgical training is of a high quality. High surgical training standards are likely to generate significant benefits for the community by excluding unqualified surgeons from the market, thereby contributing to:

- a lower rate of adverse outcomes from surgery leading to longer and better lives for patients; and

- reduced time in and/or fewer visits to hospital, thereby reducing costs for the public hospital system, Medicare, private health insurers and ultimately consumers.

Clearly, a range of other factors will also contribute to achieving these outcomes. This fact is highlighted by the establishment by health ministers in January 2000 of the Australian Council for Safety and Quality in Health Care to lead national efforts to improve patient safety and the quality of health care in Australia.

The second major public benefit claimed by the College is that surgeons organise and provide training on a pro-bono basis. In particular, they claim that surgeons provide pro-bono work valued at more than $230 million per annum (not including $70 million in capital costs).

To the extent that surgical training is provided on a pro-bono basis, the Commission considers that this constitutes a clear public benefit.
Training provided by surgeons in hospital hours – that is, the surgical apprenticeship – comprises over 90 per cent of the value of surgeons’ pro-bono work as claimed by the College. However, some state and territory governments have submitted that surgeons are paid for this training. Others agree with the College.

The Commission is unable to form a view on this important issue given the conflicting submissions it has received. The Commission has therefore invited interested parties to provide further information to assist in resolving the matter.

However, the Commission is satisfied that surgeons provide some services on a pro-bono basis. The value of these services is in the order of $20-25 million per annum.

Public detriment

The College possesses significant influence over the number of surgeons entering surgical practice. In particular, the number of trainee surgeons is limited by the number of training posts in hospitals which meet College standards. Overseas-trained surgeons entering practice in Australia are, in practice, limited by the College’s assessment as to whether they are equivalent to an Australian trained surgeon.

The College maintains that its training and assessment processes are based on the need to ensure that appropriate standards are maintained and raise no competition concerns. However, significant concerns have emerged during the course of the Commission’s assessment of the College’s application that its processes have been used to restrict the number of surgeons. These include:

- The Australian Orthopaedic Association, which administers orthopaedic surgical training on behalf of the College, ignoring a target for the number of orthopaedic surgical trainees determined by the Australian Medical Workforce Advisory Committee (AMWAC);³

- the College erecting ‘invisible barriers’ to overseas-trained surgeons wishing to enter practice in Australia – for example, by information booklets not being sent when requested, interviews not being held, or multiple interviews being held imposing considerable costs on applicants;

- the College not following or inconsistently applying assessment processes, unnecessarily delaying and not providing reasons for, decision about whether to recognise overseas-trained surgeons;

- concerns raised by interested parties – and particularly by several health ministers – about the existence of hospital training posts that have been accredited as meeting the College’s standards alongside posts which appear to be very similar, if not identical, but which have not been accredited;

- the College penally marking a key exam taken by second year basic surgical trainees. While the College has now abandoned this marking system, it appears this exam may have been used to restrict the number of basic surgical trainees able to graduate to advanced surgical training; and

³ The Australian Medical Workforce Advisory Committee was established by Commonwealth, state and territory governments to calculate the number of trainee medical specialists, including trainee surgeons, required to ensure that enough specialists exist to meet community needs.
• the string of complaints received by the Commission since it began investigating the College from, for example, surgical trainees, candidates for surgical training and overseas trained surgeons, who nearly universally are unwilling to make their complaint public for fear that the College learning of their complaint would end their chances of, for example, winning a place in the College training program. This almost universal requirement for confidentiality suggests that a widespread perception exists within the medical community that the College does not necessarily administer its training and assessment processes in an appropriate manner.

The control of entry restrictions has far-reaching consequences for the Australian community. Such restrictions affect the availability, regional distribution, quality and price of surgeons’ services. The Commission considers that the supply of such an important professional service as surgery is too important a community issue for the selection, training and assessment of surgeons to be left solely in the hands of the profession through the College and its Fellows.

In particular, surgeons undertaking selection, assessment and accreditation activities possess a conflict of interest. Requiring that surgical training standards, hospital training posts and overseas-trained surgeons meet high standards generates clear community benefits. However, unreasonably high standards inappropriately limit the size of the surgical profession thereby producing higher incomes for surgeons. More generally, the College’s expertise is in surgical practice and techniques. It is therefore not well-placed to take into account broader community considerations such as access, distribution and affordability.

Shortage of surgeons

The need for reform is particularly important given that evidence of a surgeon shortage is now emerging. The Commission engaged Professor Jeff Borland of the University of Melbourne to examine whether the current supply of surgeons is sufficient. He found likely shortages of surgeons in a majority of surgical sub-specialties including the two largest sub-specialties – general surgery and orthopaedic surgery. A copy of Professor Borland’s report is at Attachment C to the draft determination.

In addition, a number of factors suggest that there could be a severe shortage of surgeons in the coming years. These include:

• the ageing of the Australian population, which is likely to generally increase health care demands;

• the ageing of the Australian surgical profession;

• the possibility that many surgeons are considering retiring early. The Commission understands that the College recently published a survey indicating that a substantial number of surgeons were considering doing this;

• the possibility that the demand for Australian surgeons to work overseas will increase;

• the apparent reluctance of younger surgeons, and particularly female surgeons, to work the excessive hours many surgeons have traditionally worked; and

• the implementation of the Australian Medical Association’s safe working hours policy.

Again, these factors make it particularly important that unwarranted entry restrictions on
surgeons are removed and that there is greater involvement of the broader health community in the relevant decisions.

*Alternative models*

The Commission recognises that other alternative models for surgical training and assessment exist. For example, dental specialists are trained either in universities or the Royal Australasian College of Dental Surgeons. This contrasts with surgeons whose training is controlled by the College and does not involve universities. However, governments, who would ultimately be responsible for funding any new system, support the College continuing to administer its training and assessment processes so long as their concerns are addressed. The Commission also recognises the difficulties that would be faced in establishing a new system. Moreover, the Commission recognises that the College’s processes do contribute significantly to the high standards of surgery enjoyed in Australia.

*Proposed reforms*

The Commission is proposing a range of reforms to the College’s processes aimed at helping address concerns raised by interested parties. The reforms are intended to find an appropriate balance between the need for the College to remain substantially involved in the setting of surgical training and assessment standards given its technical expertise, while concerns such as those identified above are addressed.

Broadly, the Commission is proposing the College be required to:

- establish a review, through an independently chaired committee, of the criteria for accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training and implement such changes (if any) to the accreditation criteria as are recommended by the review (see Attachment D to this draft determination);

- invite health ministers to nominate persons available to participate in the assessment of hospitals (for basic surgical training) and hospital training posts (for advanced surgical training);

- invite health ministers to nominate any hospitals for basic surgical training and/or hospital training posts for advanced surgical training for which they wish to seek accreditation;

- introduce more timely processes for assessing hospitals and hospital posts and advise health departments, area health services, applicants and the general public of the outcome of its decisions;

- establish an independently chaired committee to prepare public guidelines on how it determines whether an overseas-trained surgeon is equivalent to an Australian-trained surgeon (see Attachment E to this draft determination);

- invite health ministers to nominate a panel of persons available to participate in the assessment of overseas-trained surgeons;

- introduce more timely processes for assessing overseas-trained surgeons and publish annually details of the assessment process;

- to the extent that they are not already, ensure that the College’s processes for selecting basic and advanced surgical trainees are consistent with the Brennan principles of trainee
selection (see Attachment F to the draft determination);

- invite health ministers to nominate person to selection panels for basic and advanced surgical training;

- publish annually a range of information about the College’s selection, training and examination processes, including outcomes;

- consult health ministers before finalising the limit on the number and distribution of basic surgical training posts for a particular year;

- to the extent that it has not already, reach agreements with each specialty society involved in advanced surgical training;

- alter the composition of its Appeal Committee so that it is comprised as follows:
  - three members (one of whom shall be the Chairman) nominated by the Australian Health Ministers Conference who are not College Fellows; and
  - two College Fellows from sub-specialties other than the one from which the appeal originated;

- expand its grounds for appeal against a College decision to make them more consistent with the grounds of appeal available under the Administrative Decisions (Judicial Review) Act 1977 against Commonwealth administrative decisions; and

- amend its rules to improve procedural fairness, transparency and credibility of the appeals process, including requiring the issue of written reasons for decisions.

In proposing these conditions of authorisation the Commission has considered the range of concerns raised by interested parties, and particularly state and territory governments and health ministers.

The reforms proposed are also designed to assist governments to address the specific shortage of surgeons in rural and regional areas. Trainee surgeons are an important part of the hospital workforce. The proposed reforms ensure that governments will, for the first time, be consulted on the standards that hospitals need to meet before trainee surgeons can work in them. This will allow governments input into whether a wider range of hospitals, and particularly rural and region hospitals, could accommodate trainee surgeons without any fall in training standards. It will also allow distribution of new training posts to be in accordance with community priorities.

Importantly, the Commission has not sought to alter surgical training standards by proposing these conditions. What it is proposing is that the processes by which surgical training and assessment standards are developed and implemented be altered to allow for greater input from key stakeholders – particularly state and territory governments, who are ultimately responsible for funding and providing public health care services.

The conditions of authorisation proposed by the Commission are unlikely to achieve their intended outcomes unless governments commit to making them work. For example, simply nominating unsupported lay representatives to assessment teams is unlikely to achieve much, as these representatives would typically be unlikely to be able to credibly and consistently question the views of College Fellows on the team and provide meaningful input to the team. On the other hand, the nomination of experienced and knowledgeable persons backed by the...
resources of a health department would be likely to achieve considerably more. Similarly, if governments do not commit the necessary resources to prepare significant submissions to, for example, the review of the criteria for accrediting hospitals and hospital posts, the reviews will produce little benefit.

Wider reforms

As noted above the Commission has assessed the College’s application for authorisation against the background of government workforce planning arrangements. In doing this, inadequacies in these workforce planning arrangements have become apparent. In particular:

- the methodology used by AMWAC to determine surgical training number targets needs to be improved, a view affirmed by a recent review of AMWAC. Specifically, the Commission has expressed concerns that simply to work on the basis that projections should be aimed at ensuring the ratio of surgeons to population is kept stable rather than assessing whether that ratio is appropriate in the first place would be to avoid dealing with the most fundamental issue a workforce advisory committee would address. The Commission considers that as a matter of priority, AMWAC should undertake a review of current adequacy of supply of surgeons;

- the implementation of AMWAC targets needs reform. In particular, where such a process does not already exist, there is a need for systematic process within state and territory health departments to implement AMWAC targets. If such a process is not introduced, then questions arise about the value of having AMWAC in the first place; and

- the test for determining whether overseas-trained surgeons should be able to practise in Australia should be redrafted to require that they be as competent as Australian-trained surgeons, rather than the ambiguous requirement of 'equivalency'.

These reforms, along with the reforms proposed by the Commission to the College’s training and assessment processes, should be seen as a package aimed at ensuring that a sufficient number of surgeons are practicing to meet the needs of the Australian community for high-quality surgical care into the future.

Proposed period of authorisation

The Commission proposes to grant authorisation to the College’s processes for:

- selecting basic and advanced surgical trainees;
- training basic and advanced surgical trainees; and
- examining basic and advanced surgical trainees

for six years, subject to the relevant conditions listed above.

This term will allow the Commission to re-assess these processes in the light of the assessment of the Specialist Education Accreditation Committee of the AMC in 2007 as to whether the College’s accreditation (initially granted until 31 July 2008) should be extended for a maximum of four years.

The Commission proposes to grant authorisation to the College’s processes for:

- assessing overseas-trained surgeons;
• accrediting hospitals for basic surgical training; and
• accrediting hospital posts for advanced surgical training

for four years.

These processes have attracted considerable criticism from interested parties. This warrants an earlier review by the Commission of whether the public benefit generated by these processes continues to outweigh any public detriment.

**The process from here**

The Commission will now be engaging in further consultation with the College, and interested parties, including the Commonwealth, state and territory governments, before issuing a final decision.

**Interim authorisation**

The College has had interim authorisation\(^4\) for its processes since the Commission’s consideration of its application commenced. The protection afforded by interim authorisation has been extended until the Commission issues a final determination.

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\(^4\) The ACCC may grant an interim authorisation while it considers an application for authorisation. Interim authorisation provides the same immunity from court action as provided by authorisation proper.
ATTACHMENT A

THE COLLEGE’S SUPPORTING SUBMISSION

The College argues that the arrangements for which authorisation is sought confer significant public benefits including:

- the maintenance of high surgical standards; and
- cost savings arising because surgeons consider that they provide surgical training on a pro bono basis. The College considered that the value of this pro bono work was conservatively $230 million per annum.

The number of advanced hospital training posts accredited by the College limits the number of advanced surgical trainees. The College contends that there are a range of factors which determine the number of advanced hospital posts it can accredit and that the College is a peripheral player in the overall scheme. In particular, the College argues that the overwhelming influence is the level of funding provided to hospitals (for example, salaries, hospital infrastructure and patient numbers) which they argue is a decision for federal, state and territory governments. Consequently, the College argues that its role in accrediting advanced hospital training posts does not generate any anti-competitive detriment.

In relation to overseas-trained specialists, the College argues that its role is a recommendatory one only and that state and territory medical registration boards make the final decision. Consequently, its role in the process cannot generate any anti-competitive detriment.

The College concludes that the arrangements for which it seeks authorisation confer extensive and significant public benefits which outweigh any possible anti-competitive detriment.
ATTACHMENT B

SUBMISSIONS PROVIDED BY COMMONWEALTH, STATE AND TERRITORY HEALTH MINISTERS AND AGENCIES

As noted in the body of this Executive Summary, the Commission actively sought the views of those primarily responsible for the funding and provision public health in Australia; that is, Commonwealth, state and territory governments.

General views on the College’s application

The broad view of each individual government on the College’s application for authorisation can be summarised as follows.

The Commonwealth supports granting authorisation. It considers that there is no alternative body available to take over the processes for which the College has sought authorisation. However, it supported in principle the participation of stakeholders in College processes, including the possible involvement of health departments.

NSW supports granting authorisation as long as its concerns – in particular, relating to the transparency and accountability of the College’s processes for accrediting hospital posts, assessing overseas-trained practitioners and selecting surgical trainees – are addressed.

Victoria supports granting authorisation. However, it also submits that:

while existing processes may well be soundly based, increased transparency regarding the criteria and processes for decision-making is desirable.\(^5\)

Queensland:

accepts that there is an overwhelming public benefit that derives from the activities of the specialist colleges such as the RACS in setting, developing and maintaining medical standards. It cannot accept that there is any public benefit in these activities occurring without being demonstrably fair, consistent transparent and non-discriminatory…

It is essential that the Colleges continue to develop transparent, valid and reliable processes subject to effective appeal mechanisms and external accountability to government and the Australian Medical Council. The Colleges will have little to fear from bodies such as the ACCC if these processes are in place.\(^6\)

South Australia:

is of the view that the RACS has not yet recognised the need to consult and engage the employer responsible for the funding and provision of public health services and, in particular, to assist it in addressing areas of need. Therefore it is not, in my view, ready to be granted the authorisation as requested [emphasis added].\(^7\)

Given the reference to not granting authorisation ‘as requested’, the Commission understands that South Australia’s view is broadly similar to that of NSW, Victoria and Queensland. That is, that it supports authorisation subject to its concerns being addressed.

Western Australia highlights that:

\(^5\) Submission from Victorian Minister for Health, the Hon John Thwaites, 3 October 2002, p1.
\(^6\) Submission from Queensland Minister for Health, the Hon Wendy Edmond, 25 September 2002, p3.
\(^7\) Submission from South Australian Minister for Health, the Hon Lea Stevens, 11 September 2002, p2.
the community would not accept the proposition that the government is not accountable for the availability of adequate acute specialist surgical services in the public hospital system, not to say the available of specialist surgical services generally. In reality, therefore this is not a responsibility the government can leave to an independent non-government body without adequate safeguards…

Western Australia is concerned about the apparent limitations in the accountability arrangements and transparency in the way RACS performs their essential function of training and maintaining an adequate medical specialist workforce…

Western Australia has not seen convincing evidence that justifies a hands off approach to the oversight and regulation of the processes required to ensure the supply of sufficient numbers of specialist surgeons.8

Again, the Commission understands that Western Australia would support authorisation as long as it concerns about the accountability and transparency of the College, and about its ability to determine where training posts are located (subject to accreditation requirements), were addressed.

The Australian Capital Territory submits that the:

strong influence of the College [over surgical training numbers] highlights the need for certain assurances to be undertaken by the College before the ACT government could support the Royal Australasian College of Surgeons’ application for authorisation.9

Specific issues

The views of the states and territories on some of the more contentious aspects of the College’s application can be summarised as follows.

Assessment of overseas trained surgeons

NSW Health submitted that:

the arrangements by which the College assesses the qualifications and skills of surgeons who trained overseas drew significant criticism from some [area health services] while others praised the College’s willingness to help find suitable applicants for Area of Need positions.

There was a perceived conflict between the College’s role as an advocate for its members and its role in impartially assessing new applicants who trained overseas and want to practise surgery in Australia…

The implementation of the College’s policy and procedure drew comment from the [area health services] and led to claims of invisible barriers for overseas-trained specialists. The College’s submission provides details of a fair and thorough assessment process for overseas-trained specialists. However, the experiences of some [area health services] are that the process is either not followed or inconsistently applied with examples of information booklets not being sent, interviews not being held, or multiple interviews occurring imposing considerable financial costs for applicants, particularly if applying from overseas.10

The Minister for Health in Queensland, the Hon Wendy Edmond MP, submitted that:

a common perception exists that specialist colleges have a closed shop approach to overseas-trained specialists. In practice, colleges have assisted a significant number of overseas-trained specialists to work in areas-of-need and to subsequently obtain the Fellowship of the College… Nevertheless, criticism persists in relation to the Colleges’ processes for the recognition of overseas-trained specialists…11

In particular, Ms Edmond noted concerns about the:

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8 Submission from Western Australian Minister for Health, the Hon Bob Kucera, 9 May 2002, p2.
9 Submission from ACT Minister for Health, the Hon Jon Stanhope, 23 October 2002, p1.
10 NSW Health submission, April 2002, p10.
inconsistency in standard between colleges for assessment of overseas-trained specialists. There is an impression that some colleges assess against the standard of the average Australian trained specialist while others assess against the standard of a leading specialist. Some are required to sit a part two examination while others less senior are granted fellowship after 12 months of supervised specialist practice in an area of need.\textsuperscript{12}

The South Australian Minister for Health, the Hon Lea Stevens MP, submitted that:

The Department of Human Services continues to experience a number of difficulties in relation to surgical training and surgical services. In particular, area of need is a significant issue in remote and rural communities in South Australia; there are significant difficulties in obtaining recognition of overseas-trained doctors, who are surgeons, in terms of assessment and the completion of the requirement for registration to practice as surgeons in the areas of need.

Although in one instance, after a three-year period, the [College’s] intervention has been constructive, many of its members have not been helpful in assisting the public health service to maintain and develop surgical services in remote communities in South Australia. I am not confident that the RACS is fully committed to working with my Government to ensure that the provision of surgical services in South Australia is facilitated.\textsuperscript{13}

The Commonwealth Department of Health and Ageing submitted that:

The RACS processes for the assessment of overseas trained doctors are well documented, but that is not to say the processes should not be further improved to make them more timely and transparent.

Current work being undertaken by the AMC and the Committee of Presidents of Medical Colleges (CPMC) to establish a uniform process for assessing overseas trained specialists for area-of-need positions is a positive step to addressing current inadequacies in assessment processes. The Department considers it vital that this work is extended to develop a uniform process for the assessment by Specialist Medical Colleges of all overseas trained specialists.\textsuperscript{14}

Accredited and non accredited training posts

NSW Health submitted that:

the College needs to clearly justify its decisions in relation to the accreditation of some surgical positions and not others. This is especially important for non-accredited positions where the doctors filling these positions perform similar work, have the same working conditions, have access to the same hospital training facilities (the medical library, formal clinical meetings and surgical education meetings) and receive similar level of supervision as accredited trainees.\textsuperscript{15}

The Department of Human Services in Victoria submitted that:

the process by which the College accredits surgical trainee posts at specific hospital locations is not necessarily made clear to the Department and the hospitals concerned. It is important that this accreditation process is fully transparent to demonstrate that the College is objective in its workings and that the service requirements of the hospital are not unduly restricted.\textsuperscript{16}

Queensland Health submitted that:

funded unaccredited and accredited posts exist side by side, often carrying out identical service roles and participating in the same teaching activities.\textsuperscript{17}

\textsuperscript{12} Ibid, p2.
\textsuperscript{13} Submission from South Australian Minister for Health, the Hon Lea Stevens, 11 September 2002, p1.
\textsuperscript{14} Commonwealth Department of Health and Ageing submission, June 2001, pp21-22.
\textsuperscript{15} NSW Health submission, 13 November 2001, p5.
\textsuperscript{17} Queensland Health submission, 4 May 2001, p3.
The ACT Minister for Health, Mr Stanhope MLA submitted that:

the reasons for some training posts being accredited whilst others are not are not always clear. Clarity in the reasons for these decisions is needed as there is often little difference between accredited and non-accredited training posts.\(^{18}\)

*General lack of transparency*

The Minister for Health in Western Australia, the Hon Bob Kucera MP submitted that:

the present arrangements do not provide sufficient information for government to determine the extent to which RACS policies and processes… are factors contributing to shortages of surgeons…\(^{19}\)

NSW Health submitted that:

there is a potential to increase the public benefit of the College’s arrangements through more open and transparent processes for selection of advanced trainees, accreditation of hospital posts and the assessment of overseas-trained specialists…\(^{20}\)

*Rural and regional areas*

The Victorian Minister for Health, the Hon John Thwaites MP, submitted that:

The State supports the proposal to broaden existing accreditation processes to provide opportunities for input from other key stakeholders (for example, other medical colleges) in order to facilitate development of approaches to training which will provide a broad range of experience for trainees. I am particularly conscious of the requirements of regional and rural areas and the importance of ensuring there is appropriate consideration of the need for rural training opportunities and models which might better support these.\(^{21}\)

NSW Health submitted that it was concerned that the College’s standards for accrediting advanced hospital posts:

may be inappropriately applied to rural and outer metropolitan hospitals if these hospitals are required to meet the same infrastructure standards as large teaching hospitals. For example, the College’s accreditation standards may disadvantage hospitals which provide excellent surgical training opportunities but do not have access to the same resident medical officer staffing levels that large inner city teaching hospitals have. It is a question of the College achieving a reasonable balance between ensuring minimum training standards for all accredited positions while allowing some flexibility in order to recognise the complementary training benefits offered by different types of hospital.\(^{22}\)

The Minister for Health in Western Australia, the Hon Bob Kucera APM MLA, submitted that:

there is good reason to believe that the location of medical specialist training is an important factor in influencing the long term geographic distribution of medical specialist services. For example, it has been acknowledged that training location is an important factor in assisting the long term supply of medical specialists willing to work in rural areas. As a result a trend has commenced to give increased emphasis to establishing medical specialist training posts in rural regional hospitals. A similar argument and strategy could be mounted in respect to achieving the necessary supply of medical specialist in the fast growing outer suburbs

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\(^{18}\) Submission from ACT Minister for Health, the Hon Jon Stanhope, 21 October 2002, p1.

\(^{19}\) Submission from the Western Australian Health Minister, the Hon Bob Kucera, 9 May 2002, p2.

\(^{20}\) NSW Health submission, 13 November 2001, p2.

\(^{21}\) Submission from Victorian Minister for Health, the Hon John Thwaites, 30 September 2002, p2.

\(^{22}\) NSW Health submission, April 2002, pp7-8.

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of many of the state capital cities. It is important then that there are not artificial barriers limiting the geographical spread of surgeon training posts.23

The distribution of surgical training posts – government involvement

The Victorian Minister for Health, the Hon John Thwaites MP, submitted that:

it is desirable to move towards a situation where the state actively determines the distribution of centrally subsidised medical specialist training positions, including surgical training posts, whilst acknowledging hospitals will need to create additional training positions to support service needs where necessary.24

NSW Health submitted that:

[ultimately decisions concerning the number and distribution of surgical training posts within the NSW public health service should be a matter for NSW Health to determine in consultation with the College and the NSW Medical Training and Education Council. This will require greater collaboration between the various stakeholders than occurs at present.25

23 Submission from Western Australian Minister for Health, the Hon Bob Kucera, 9 May 2002, p3.
24 Submission from Victorian Minister for Health, the Hon John Thwaites, 30 September 2002, p2
### Abbreviations

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<th>Abbreviation</th>
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<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Committee</td>
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<td>AHMC</td>
<td>Australian Health Ministers’ Conference</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMC</td>
<td>Australian Medical Council</td>
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<tr>
<td>AMWAC</td>
<td>Australian Medical Workforce Advisory Committee</td>
</tr>
<tr>
<td>AST</td>
<td>Advanced Surgical Training</td>
</tr>
<tr>
<td>BAST</td>
<td>Board of Advanced Surgical Training</td>
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<tr>
<td>BBST</td>
<td>Board of Basic Surgical Training</td>
</tr>
<tr>
<td>College</td>
<td>The Royal Australasian College of Surgeons</td>
</tr>
<tr>
<td>BST</td>
<td>Basic Surgical Training</td>
</tr>
<tr>
<td>Commission</td>
<td>The Australian Competition and Consumer Commission</td>
</tr>
<tr>
<td>the Act</td>
<td>The <em>Trade Practices Act 1974</em></td>
</tr>
</tbody>
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1. **INTRODUCTION**

1.1 The Australian Competition and Consumer Commission is the Commonwealth agency responsible for administering the *Trade Practices Act 1974*. A key objective of the Act is to prevent anti-competitive conduct, thereby encouraging competition and efficiency in business, resulting in a greater choice for consumers in price, quality and service.

1.2 The Act, recognises that competition may not always be in the best public interest. It therefore allows the Commission to grant immunity from the Act for anti-competitive conduct in certain circumstances.

1.3 One way businesses may obtain immunity is to apply for what is known as an ‘authorisation’ from the Commission. Broadly, the Commission may ‘authorise’ businesses to engage in anti-competitive conduct where it is satisfied that the public benefit from the conduct outweighs any public detriment.

1.4 The Commission conducts a comprehensive public consultation process before making a decision to grant or deny authorisation.

1.5 Upon receiving an application for authorisation, the Commission invites interested parties to lodge submissions outlining whether they support the application or not, and their reasons for this.

1.6 The Act requires that the Commission then issue a draft determination in writing proposing either to grant the application (in whole, in part or subject to conditions) or deny the application. In preparing a draft determination, the Commission will take into account any submissions received from interested parties.

1.7 This document is a draft determination in relation to application for authorisation A90765 lodged with the Commission by the Royal Australasian College of Surgeons (the College).

1.8 Once a draft determination is released, the applicant or any interested party may request that the Commission hold a conference. A conference provides interested parties with the opportunity to put oral submissions to the Commission in response to a draft determination. The Commission will also invite interested parties to lodge written submissions on the draft.

1.9 The Commission then reconsiders the application taking into account the comments made at the conference (if one is requested) and any further submissions received and issues a written final determination.

**Extension of the Trade Practices Act to the professions**

1.10 When it was enacted in 1974, for constitutional reasons, the Act only applied to incorporated businesses. However, in April 1995, Commonwealth, state and territory governments agreed to extend the provisions of the Act prohibiting anti-competitive conduct to unincorporated businesses, including the professions.

1.11 Subsequently, each of the Australian State and Territory Parliaments passed legislation extending the competition provisions of the Act to unincorporated businesses. This was done by mirroring the competition provisions of the
Act in the Competition Code in each jurisdiction. Since that time, the competition provisions of the Act have been applied to all professionals, including health practitioners such as surgeons. Moreover, professional associations and professionals have been able to apply for authorisation, and thereby obtain immunity from these provisions.

The College’s application

1.12 On 28 November 2000, the College lodged application A90765 with the Commission. The application was made under subsection 88(1) of the Act and the Competition Codes for each state and territory for authorisation to give effect to a contract, arrangement or understanding, a provision of which has the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

1.13 A full submission in support of the application for authorisation was lodged by the College with the Commission on 30 March 2001.

1.14 The application seeks authorisation for the College’s processes in:

- selecting, training and examining basic surgical trainees and advanced surgical trainees in each of the nine specialities in which it conducts training;
- accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training; and
- assessing the qualifications of overseas-trained surgeons.

1.15 These processes are referred to in this draft determination as the College’s **training and assessment processes**. The College seeks authorisation of its training and assessment processes for an indefinite period of time.

Entering surgical practice in Australia

1.16 Surgeons practising in Australia have either:

- completed the College’s training program; or
- are overseas-trained practitioners whose qualifications and experience have been assessed as being equivalent to Australian-trained surgeons, or assessed as being competent to perform specific procedures (outlined within a position description) in areas where there is a shortage of doctors (that is, an area-of-need position).

1.17 An overview of entering surgical practice in Australia and the limits on entering the surgical profession in Australia is provided in Chapter 2 of this decision. Chapters 6, 7 and 8 examine the role of the College, the Australian Health Ministers’ Conference (and the Australian Medical Workforce Advisory Committee) and of individual state and territory governments respectively.

Commission investigation preceding application for authorisation

1.18 Following the extension of the Act to the professions, the Commission began receiving complaints that the College’s processes restrict entry to advanced
surgical training in breach of the Act.

1.19 In 1998, the Commission commenced investigating the College’s role in determining the number of trainees in orthopaedic surgery and how it assesses overseas-trained specialists. In September 2000, it informed the College that it considered that this conduct may breach the Act. On 9 October 2000, the College indicated that it would be applying for authorisation. On 19 October 2000, the Commission stated that it would suspend its investigation while the application was being genuinely pursued.

1.20 The College subsequently applied for authorisation of its processes as described above at paragraphs 1.12 – 1.14.

1.21 The College asserts that none of its training and assessment processes breach the Act. Nevertheless, the College submits that it has applied for authorisation to remove any uncertainty regarding this issue\textsuperscript{26}.

Previous inquiries

1.22 In 1988, the Doherty Report\textsuperscript{27} concluded that the medical workforce should be monitored more closely than in the past, and recommended the establishment of an ongoing ‘Medical Workforce Review Committee’.

1.23 In recent years, a number of inquiries have examined aspects of the College’s training program and/or its assessment of overseas-trained surgeons. These include:

- the Baume Inquiry\textsuperscript{28}, which examined a wide range of issues relating to the surgical workforce including workforce numbers, distribution of surgeons, surgical remuneration, waiting lists, hospital staffing and surgical training;
- the 1998 Brennan Review\textsuperscript{29} of selection processes of medical colleges and the development of a ‘best practice’ framework for trainee selection; and
- the Race to Qualify Report\textsuperscript{30}, which examined a wide range of issues in relation to the assessment and registration of permanent and temporary resident doctors trained overseas.

1.24 Also, in February 2002, the Australian Medical Council (AMC) released its findings from its review of the specialist education and training programs of the College. The College was granted AMC accreditation for its training and education programs for six years, extendable to ten years, subject to certain requirements being met.

Interim Authorisation

1.25 On 30 March 2001, the College requested interim authorisation for its training and assessment processes. The College requested interim authorisation on the grounds that interim authorisation was necessary to protect it from any civil claims that may

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\textsuperscript{26} The Royal Australasian College of Surgeons, supporting submission to the application for authorisation, 30 March 2001, page 5.
\textsuperscript{27} Australian Medical Education and Workforce into the 21\textsuperscript{st} Century – Report of the Committee of Inquiry into Medical Education and Workforce, 1988.
\textsuperscript{28} A Cutting Edge: Australia’s Surgical Workforce, Report of the Inquiry into and Supply of, and Requirements for, Medical Specialist Services for Australia, 1994.
\textsuperscript{29} Trainee Selection in Australian Medical Colleges, January 1998.
arise in respect of its training and assessment procedures prior to the Commission determining the substantive application.

1.26 On 4 May 2001, the Commission granted interim authorisation for the College’s training and assessment processes until the date of the Commission’s issuing of a draft determination in relation to the application for authorisation, or 31 December 2001, whichever was the earlier.

1.27 On 1 November 2001, Commission amended the period of interim authorisation to be until the date the Commission issues a draft determination.

1.28 The Commission extends interim authorisation until a final determination is issued.

Chronology

1.29 The chronology of the Commission’s consideration of application A90765 is summarised in Table 1.1 below.

1.30 The Commission has conducted an extensive consultation process in its consideration of the College’s application. In particular, the Commission recognises the integral role that state and territory governments play in the training and assessment processes for surgeons. For example, it is the role of state and territory governments to provide funding for training places within public hospitals. In this regard, the Commission actively sought the view of state and territory government health ministers and agencies.
<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 November 2000</td>
<td>Application for authorisation received from the Royal Australasian College of Surgeons (the College).</td>
</tr>
<tr>
<td>30 March 2001</td>
<td>Received substantive submission in support of the application for authorisation and related attachments from the College. At this time, the College applied for interim authorisation of its training procedures.</td>
</tr>
<tr>
<td>2 April 2001</td>
<td>Letters seeking comment on the application sent to interested parties. The closing date for submissions was 4 May 2001.</td>
</tr>
<tr>
<td>19 April 2001</td>
<td>The Commission denied interim authorisation based on limited information supplied by the College to support the request. However, the Commission indicated it would be willing to reconsider a further submission for interim authorisation and indicated the key issues required to be addressed.</td>
</tr>
<tr>
<td>23 April 2001</td>
<td>Request to reconsider interim authorisation received from the College.</td>
</tr>
<tr>
<td>26 April 2001</td>
<td>Commission requests additional information from the College in support of the request for interim authorisation.</td>
</tr>
<tr>
<td>30 April 2001</td>
<td>Additional information received from the College in support of interim authorisation.</td>
</tr>
<tr>
<td>4 May 2001</td>
<td>Based on the additional information, the Commission granted interim authorisation for the College’s training and assessment processes.</td>
</tr>
<tr>
<td>11 May 2001</td>
<td>Commission seeks additional information from the College regarding its application.</td>
</tr>
<tr>
<td>17 May 2001</td>
<td>Additional information received from the College, including a copy of the College’s accreditation submission to the Australian Medical Council (AMC) and accompanying folder of attachments.</td>
</tr>
<tr>
<td>17 August 2001</td>
<td>Commission letter seeking additional information from state and territory health departments.</td>
</tr>
<tr>
<td>27 August 2001</td>
<td>Submission received from Department of Health and Human Services Tasmania in relation to August issues letter.</td>
</tr>
<tr>
<td>30 August 2001</td>
<td>Meeting with Health Department of Western Australia in relation to August issues letter.</td>
</tr>
<tr>
<td>13 September 2001</td>
<td>Meeting with ACT Department of Health, Housing and Community Care in relation to August issues letter.</td>
</tr>
<tr>
<td>2 October 2001</td>
<td>Meeting with Queensland Health in relation to August issues letter.</td>
</tr>
<tr>
<td>Date</td>
<td>Action</td>
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<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17 October 2001</td>
<td>Letter from the College seeking an extension of interim authorisation until the application for authorisation is finalised.</td>
</tr>
<tr>
<td>1 November 2001</td>
<td>The Commission amended its original decision so that interim authorisation extends until the Commission issues its draft determination.</td>
</tr>
<tr>
<td>13 November 2001</td>
<td>Received submission from NSW Health.</td>
</tr>
<tr>
<td>16 November 2001</td>
<td>Letter from the College requesting that the Commission extend interim authorisation until a final determination is issued.</td>
</tr>
<tr>
<td>5 December 2001</td>
<td>The Commission maintained its decision of 1 November 2001 in respect to interim authorisation.</td>
</tr>
<tr>
<td>7 December 2001</td>
<td>Commission seeks further information from NSW Health.</td>
</tr>
<tr>
<td>14 December 2001</td>
<td>Letter to the Department of Human Services Victoria in relation to specific issues arising from the public consultation process.</td>
</tr>
<tr>
<td>14 December 2001</td>
<td>Letter to the College seeking further information on specific issues arising from the public consultation process.</td>
</tr>
<tr>
<td>18 January 2002</td>
<td>Received information from Department of Human Services Victoria in response to December issues letter.</td>
</tr>
<tr>
<td>20 March 2002</td>
<td>Received information from the College in response to December issues letter.</td>
</tr>
<tr>
<td>15 April 2002</td>
<td>Received further submission from Western Australian Department of Health.</td>
</tr>
<tr>
<td>9 May 2002</td>
<td>Submission received from the Hon Bob Kucera, Minister for Health Western Australia.</td>
</tr>
<tr>
<td>10 May 2002</td>
<td>Received additional submission from NSW Health.</td>
</tr>
<tr>
<td>19 July 2002</td>
<td>Commonwealth, state and territory health ministers’ requested a copy of the College’s application and a further opportunity to comment on or provide personal input into the Commission’s public consultation process.</td>
</tr>
<tr>
<td>24 July 2002</td>
<td>Received outstanding information from the College in response to December issues letter.</td>
</tr>
<tr>
<td>6 August 2002</td>
<td>Commission wrote to Commonwealth, state and territory health ministers’, in response to request made by the Australian Health Ministers’ Conference at its meeting on 19 July 2002 in Darwin.</td>
</tr>
<tr>
<td>11 September 2002</td>
<td>Received submission from the Hon Lea Stevens, South Australian Minister for Health.</td>
</tr>
<tr>
<td>Date</td>
<td>Action</td>
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<td>---------------------</td>
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</tr>
<tr>
<td>25 September 2002</td>
<td>Received additional information from the Hon Bob Kucera, Western Australian Minister for Health.</td>
</tr>
<tr>
<td>25 September 2002</td>
<td>Received submission from the Hon Wendy Edmond, Queensland Minister for Health.</td>
</tr>
<tr>
<td>30 September 2002</td>
<td>Received submission from the Hon John Thwaites, Victorian Minister for Health.</td>
</tr>
<tr>
<td>10 October 2002</td>
<td>Received submission from Senator the Hon Kay Patterson, Commonwealth Minister for Health and Ageing indicating that the relevant issues had been addressed in the previous submission from the Commonwealth Department of Health and Ageing.</td>
</tr>
<tr>
<td>23 October 2002</td>
<td>Received submission from Jon Stanhope, ACT Minister for Health.</td>
</tr>
<tr>
<td>24 October 2002</td>
<td>Received letter from the Hon Craig Knowles, New South Wales Minister for Health indicating that the relevant issues had been addressed in the previous submissions from NSW Health.</td>
</tr>
</tbody>
</table>

**Overview of the draft determination**

1.31 The draft determination consists of fifteen chapters. These are:

- Chapter 2 – an overview of the system for entering surgical practice in Australia;
- Chapter 3 – a statistical overview of the surgical workforce in Australia;
- Chapter 4 – the history of surgical training in Australia;
- Chapter 5 – the College;
- Chapter 6 – the College’s training and assessment processes for which authorisation is sought;
- Chapter 7 – the role of the Australian Health Ministers’ Conference and Australian Medical Workforce Advisory Committee in workforce planning;
- Chapter 8 – the role of individual state and territory governments;
- Chapter 9 – greater detail in relation to the net public benefit test applied by the Commission in its consideration of the application for authorisation;
- Chapters 10 and 11 – summary of the submissions received by the Commission on the application for authorisation from the College and various interested parties; and
- Chapter 12 – the Commission’s evaluation of the application;
- Chapter 13 – concluding remarks; and
- Chapter 14 – the Commission’s draft determination.
2. ENTERING SURGICAL PRACTICE IN AUSTRALIA – AN OVERVIEW

Practising surgery in Australia

2.1 Surgeons in Australia may choose to practise in the public and/or private sector in one of nine sub-specialties.

Surgical sub-specialties

2.2 General surgery, while technically encompassing any type of surgery, is in practice largely limited in practice to operations not usually performed by other sub-specialties.

2.3 Cardiothoracic surgery is surgery relating to the heart and chest.

2.4 Neurosurgery is surgery on the nervous system, including the brain and spinal cord.

2.5 Orthopaedic surgery is surgery of the muscular skeletal system as a whole, including the treatment of bones which have not grown correctly or which have been damaged.

2.6 Otolaryngology – head and neck surgery deals with the diagnosis and treatment of diseases of the ear, nose and throat.

2.7 Paediatric surgery is the surgical treatment of children.

2.8 Urology deals with the diagnosis and treatment of diseases of the urinary tract and urogenital system.

2.9 Vascular surgery is a branch of medicine dealing with the use of surgery to diagnose/treat diseases of the blood vessels.

2.10 Plastic and reconstructive surgery is surgery to reduce scarring or disfigurement that may occur as a result of accidents, birth defects or treatment for diseases.

Public sector

2.11 Patients are entitled to be treated for free in public hospitals administered by state and territory governments.

2.12 Surgeons who work in the public hospitals are either:

- engaged as Visiting Medical Officers (VMOs), usually on a part-time basis; or
- employed as salaried medical officers, usually on a full-time basis.

2.13 These surgeons are paid by the entity that has engaged them, rather than by the patient.

Private sector

2.14 Surgeons who wish to work in the private sector must obtain two approvals.

2.15 First, the Commonwealth government funds the Medicare system, under which
patients are entitled to receive rebates to assist in meeting the cost of doctors’ services. Surgeons must be recognised by the Health Insurance Commission before their patients may receive Medicare rebates. This is discussed further at paragraphs 2.46–2.57.

2.16 Second, surgeons who work in the private sector must be approved by a private hospital before being able to perform procedures there. The Commission understands that private hospitals determine whether to approve a new surgeon acting on the advice of ‘credentialing’ committees usually constituted by surgeons already approved to work at the hospital.

Entering the surgical profession in Australia – locally trained surgeons

2.17 Persons (other than overseas-trained practitioners) wishing to enter the College’s surgical training program must first complete a Bachelor of Medicine and Bachelor of Surgery (MBBS) or equivalent at an Australian university and an intern year.31 They then have to apply to the College for a place in its basic surgical training program. Trainees move through a minimum of two years of basic surgical training (in general surgical practice and principles) after which they apply for a position in one of the advanced surgical training programs in each surgical sub-specialty. These programs are between four and six years in length and culminate in a final year examination. Trainees who complete the College’s surgical training program are granted a College Fellowship. Greater detail about the College’s training processes is provided in chapter 4 of this draft determination.

Limits on entering the surgical profession in Australia – locally trained surgeons

2.18 There are a number of influences on the number of surgeons trained in Australia. Figure 2.1 below depicts the limits on the number of locally trained surgeons entering the surgical profession in Australia. These limits include:

- the Commonwealth government limits the number of subsidised medical school places;
- target numbers of advanced surgical training places determined by the Australian Medical Workforce Advisory Committee (AMWAC) and endorsed by the Australian Health Ministers’ Conference (AHMC);
- the number of advanced surgical training posts accredited by the College (and the number of hospitals accredited by the College to undertake basic surgical training); and
- the amount of funding provided by state and territory governments to ensure that the College’s accreditation criteria are met.

2.19 The number of surgeons trained is also dependent on the number of applicants attracted to each of the surgical sub-specialties. The Commission understands for example that the number of qualified applicants to the neurosurgery training program

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31 This will generally enable them to be registered as a medical practitioner – see paragraphs 2.33–2.35. South Australia and Queensland also have specialist medical registers. The award of a College Fellowship upon completion of the College’s training program would entitle surgeons to specialist registration (see paragraphs 2.36–2.38).
of the College has decreased in recent years. AMWAC reports that the main reasons for this may be related to the nature of neurosurgery work (that is, demands of a neurosurgery practice and hours of work), the cost of medical indemnity insurance and working conditions.32

Figure 2.1: Limits on the number of surgeons trained in Australia

* The number of basic surgical training places is also limited to the availability of places in the basic training skills courses, which is dependent on the number of trainers from the College.

33 Figure 2.1 compiled by the Australian Competition and Consumer Commission.
Medical school places

2.20 The Commonwealth Department of Health and Ageing is responsible for monitoring university medical school intakes and the distribution of medical school places. The Commonwealth also limits the number of subsidised medical school places. In 1999, 1334 students commenced an undergraduate degree in medicine, compared to 860 students in 1995 and 1392 students in 1991.34

Australian Medical Workforce Advisory Committee (AMWAC)

2.21 In 1995 the Australian Health Ministers’ Conference established the Australian Medical Workforce Advisory Commission (AMWAC) to provide advice on the number of medical specialist training places required to ensure that future workforce numbers are sufficient to meet patient demand.

2.22 The number of advanced surgical training places is therefore influenced by the workforce planning recommendations of AMWAC. Ultimately, health ministers endorse the target number of advanced surgical training posts in each state and territory acting on the advice of AMWAC. The role of AMWAC in medical workforce planning in Australia is discussed in greater detail in chapter 7 below.

Implementation of AMWAC recommendations by states and territories

2.23 Implementation of health ministers’ decisions regarding the number of surgical trainees requires action by state and territory health departments and the College. Where an increase in the number of trainees is required in a particular surgical subspeciality, these new positions must meet the College’s standards for training posts. To achieve this increase, state and territory governments would need to ensure that sufficient funding is provided to public hospitals to ensure that the required number of training posts meets the College’s accreditation standards. The role of individual health departments is discussed in greater detail in Chapter 8.

College accreditation of hospital posts for advanced surgical training and hospitals for basic surgical training

2.24 The College determines the criteria which must be met by hospital posts to be accredited for advanced surgical training and hospitals to be accredited for basic surgical training. Teams appointed by the College assess whether hospitals and hospital posts, as the case may be, meet its accreditation criteria. As previously noted, the College’s training and assessment processes are detailed in Chapter 6.

Entering the surgical profession in Australia – overseas-trained surgeons

2.25 Overseas-trained surgeons wanting to practise surgery in Australia must first satisfy Australian immigration requirements. They must also obtain medical registration from the relevant state or territory medical registration board. Overseas-trained surgeons wanting to enter private practice must obtain a Medicare provider number.

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Limits on overseas-trained surgeons entering the surgical profession in Australia

2.26 Limits on overseas-trained surgeons entering the surgical practice in Australia include:

- Australian immigration requirements;
- the need to be registered by state and territory medical registration boards, which entails the overseas-trained surgeon being assessed by the College; and
- the Commonwealth government’s ten year moratorium on granting Medicare provider numbers to overseas-trained practitioners.

Areas-of-need

2.27 ‘Areas-of-need’ are areas in each state and territory – usually rural and regional areas – where the state or territory government has determined there is a shortage of doctors.  

2.28 To encourage overseas-trained doctors to work in areas-of-need, various exemptions from immigration, medical registration and Medicare restrictions are provided to overseas-trained doctors who opt to work in these areas. These exemptions are noted in the relevant sections below.

Immigration requirements

2.29 Overseas-trained surgeons (who are not already Australian citizens or permanent residents) must first satisfy Australia’s immigration requirements before being able to practise in Australia.

2.30 To control growth in the number of doctors in Australia, medical practitioners are excluded from the major elements of Australia’s skilled migration stream; that is, the Skilled-Independent and Skilled Australian-sponsored visa categories.

2.31 Having said this, a number of ways exist by which overseas-trained doctors can obtain visas that would allow them to reside permanently in Australia. For example:

- they may be sponsored by their Australian spouse under the family migration stream of Australia’s migration program. It appears that, in 1996 at least, most medically trained migrants fell into this category;
- they may apply under the Employer Nomination Scheme (ENS) or the Regional Sponsored Migration Scheme (RSMS). These schemes are designed to enable Australian employers to recruit highly skilled workers from overseas where they are unable to fill vacancies locally. For example, a public hospital in an area-of-need could seek to sponsor an overseas-trained surgeon under the ENS or RSMS.

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35 See, for example, Medical Practice Act 1992 (NSW), section 7D; Medical Practitioners Registration Act 2001 (Qld), section 135; Medical Act 1894 (WA), section 11AF(1)(D).
36 Ibid.
38 Media release, New Arrangements for Overseas-trained Doctors, Dr Michael Wooldridge, Minister for Health and Family Services, 29 October 1996.
However, before applying under these schemes, an overseas-trained surgeon would need to apply to the Australian Medical Council for an assessment of his or her experience and qualifications – which would be undertaken by the College (see Chapter 6);\(^{39}\) and

- some overseas-trained surgeons may qualify under Australia’s refugee and humanitarian program.

2.32 Doctors may also obtain temporary resident visas to fill hospital positions in areas-of-need. Visas are generally granted for as long as the doctor’s conditional registration by the state or territory medical board extends (which will be for the length of the contract of employment).\(^{40}\)

**College assessment of overseas-trained surgeons for purposes of registration by state and territory medical boards**

2.33 All states and territories have enacted legislation:

- limiting the practice of medicine to registered medical practitioners; and/or
- prohibiting unregistered persons from holding themselves out to be medical practitioners.\(^{41}\)

2.34 Generally, persons are eligible to be registered as medical practitioners if they:

- have graduated from a medical school accredited by the Australian Medical Council or have successfully completed examinations held by the Council for the purposes of registration as a medical practitioner;
- have completed an internship or period of supervised training; and
- are fit and proper to practise as a medical practitioner.\(^{42}\)

2.35 The registration system is administered by medical registration boards in each state and territory.

2.36 While most registered medical practitioners are general practitioners, specialists including surgeons must also be registered.

2.37 South Australia and Queensland also have specialist medical registers. In South Australia, regulations specify the specialties in which medical practitioners may be registered. These include all nine surgical sub-specialties of the College.\(^ {43}\) Broadly, persons may be registered as a surgeon in any one of these sub-specialties if they:

- are registered as a general medical practitioner;

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\(^{39}\) Overseas doctors seeking permanent residence in Australia, Form 1062i, Department of Immigration and Multicultural and Indigenous Affairs website, www.immi.gov.au.

\(^{40}\) Ibid.

\(^{41}\) For example, see Medical Practice Act 1994 (Vic), section 62; Medical Practitioners Act 1983 (SA), sections 30, 31; and Medical Practice Act 1992 (NSW), sections 99, 105.

\(^{42}\) For example, see Medical Practice Act 1992 (NSW), sections 4 and 13; Medical Practitioners Registration Act 1996 (Tas), sections 19 and 24; and Medical Act 1894 (WA), sections 11 and 11AA.

\(^{43}\) Medical Practitioners Regulations 1983, Schedule 3.14
• are a Fellow of the College or hold a certificate or other document issued by the Australian Medical Council stating that they have attained a satisfactory standard for recognition as a specialist in that speciality; and

• are fit and proper to be registered.44

2.38 A person may not hold themselves out to be a specialist unless they are registered as a specialist.45

2.39 The Commission understands that Queensland’s scheme is similar.46

2.40 State and territory medical registration boards may grant conditional registration to overseas-trained doctors surgeons that entitles them only work in a particular position in an area-of-need.

2.41 Prior to 1990, overseas-trained specialists were required to pass an examination aimed at general practitioners to be registered by a state or territory medical board. Since 1990, under a system agreed by Commonwealth, state and territory health ministers, medical boards act on recommendations provided by the College about whether overseas-trained surgeons are either:

• equivalent to Australian-trained specialists; or

• if the overseas-trained specialist is proposing to work in an area of need, that he or she is competent to perform the procedures required to be performed in the specific area-of-need position.

2.42 Medical registration boards act in accordance with the College’s recommendations about overseas-trained practitioners in most, if not all, cases.

2.43 The Commission understands that being assessed by the College as being equivalent to an Australian-trained surgeon would entitle an overseas-trained surgeon to general and specialist registration.

2.44 More detail in relation the College’s assessment of overseas-trained surgeons is provided in Chapter 6.

2.45 The same system for assessing overseas-trained specialists applies for all other medical specialties.

Private practice – Medicare

2.46 In practice, overseas-trained surgeons would only be able to work in private practice if their patients were eligible to receive Medicare rebates.

2.47 Generally, surgical patients are eligible to receive the higher Medicare rebates payable for services provided by specialists where:

45 Medical Practitioners Act 1983 (SA), section 30.
46 Medical Practitioners Registration Act 2001 (Qld), section 111; Medical Practitioners Registration Regulation 2002, Part 3 and Schedule 1.
• they are private patients of surgeons (ie they are not seen by a surgeon in his or her role as a Visiting Medical Officer or salaried surgeon at a public hospital);

• the surgeon is recognised as a specialist under the *Health Insurance Act 1973* (HIA).

2.48 Surgeons will be recognised as a specialist under the HIA if the College gives the Managing Director of the Health Insurance Commission a written notice stating that the surgeon:

• is domiciled in Australia;

• is a Fellow of the College; and

• has obtained, as a result of successfully completing an appropriate course of study, a relevant qualification in relation to the College.47

2.49 Overseas-trained surgeons who are domiciled in Australia but who are not College Fellows need to lodge an application with the HIC accompanied by a detailed curriculum vitae, a certified copy of their medical registration, referees’ details, copies of qualifications and the relevant fee.

2.50 Overseas-trained surgeons who entered Australia on or after 1 January 1997 first need to obtain an exemption from the Department of Health and Ageing from the ten-year moratorium on granting Medicare provider numbers to overseas trained practitioners. An exemption is available where overseas-trained surgeons propose to work in districts of workforce shortage (generally rural and remote areas, and the public hospital sector).48 Without an exemption, these surgeons are effectively limited to salaried medical positions.

2.51 The application is referred to a Specialist Recognition Advisory Committee (SRAC), which assesses the application having regard to the following criteria:

• the qualifications of the medical practitioner; and

• the experience and the standing in the medical profession of, and the nature of the practice of, the medical practitioner.

2.52 The SRAC refers the application to the College for a written assessment of the applicant’s clinical experience and training. It also requests referees to provide a written reference addressing the criteria above.49

2.53 Overseas-trained surgeons who are not domiciled in Australia – that is, temporary resident doctors (TRDs) – also initially need to obtain an exemption from the Department of Health and Ageing from the ten-year moratorium on granting Medicare provider numbers to overseas trained practitioners. As indicated above, an exemption is available where TRDs propose to work in districts of workforce shortage.50

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48 Information provided by Health Insurance Commission (HIC), 22 October 2001, p2; DHA submission, June 2001, p22.
49 Information provided by HIC, 22 October 2001, pp1-2.
50 Information provided by HIC, 22 October 2001, p2; DHA submission, June 2001, p22.
2.54 Once TRDs have obtained this exemption, they may apply to the HIC, which refers applications to an Overseas Specialist Advisory Committee (OSAC). An OSAC then assesses the surgeon’s application using the same process used for overseas-trained surgeons who are domiciled in Australia – in particular, the matter is referred to the College. However, an OSAC is able to take into account the overall merits of the case, including the area of workforce shortage in relation to which the doctor has been granted an exemption. If granted, specialist recognition will extend for the term of the exemption from the ten-year moratorium, at which time the surgeon needs to re-apply (although if circumstances have not changed, the matter will not be re-submitted to an OSAC or the College).\(^5^1\)

2.55 SRAC decisions may be appealed to a Specialist Recognition Appeal Committee and OSAC decisions to an Overseas Specialist Appeal Committee.\(^5^2\)

2.56 There are six SRACs and six OSACs – that is, one for each state, with the ACT combining with NSW and the Northern Territory combining with South Australia. Each SRAC/OSAC and their respective appeal committees have five members. SRACs and OSACs have the same members and meet at the same time. Before making an appointment to these committees, the Minister must request the following bodies to nominate three candidates:

- the Australian Medical Association;
- the College;
- the Royal Australasian College of Physicians;
- the Royal Australian College of Obstetricians and Gynaecologists; and
- the Royal Australian College of General Practitioners.\(^5^3\)

2.57 Generally, the HIC indicated that SRACs/OSACs would be unlikely to act against the advice of the College. It also indicated that, where the College considers that a doctor is deficient in some way, it is generally detailed in its response to the SRAC/OSAC.\(^5^4\)

Example – overseas-trained surgeon entering Australia under family migration program

2.58 As indicated above, it appears that, given the restrictions on the immigration of doctors, most doctors enter Australia under the family migration program by virtue of having an Australia spouse. Figure 2.2 illustrates the limits on these surgeons entering practice in Australia.

\(^{51}\) Information provided by HIC, 22 October 2001, p2,3.
\(^{52}\) Ibid, p3.
\(^{53}\) Ibid, pp2-3.
\(^{54}\) Ibid, p3.
Figure 2.2: Limits on overseas-trained surgeons entering Australia under family migration scheme entering surgical practice in Australia

Salaried position in a public hospital.  
Private practice.

The College makes recommendation:
- whether equivalent to locally trained surgeon; or
- whether competent to perform specified procedures for area of need position.

Registration from State/Territory Medical Board (nearly always accepts College recommendation).

Australian Medical Council (AMC).

AMC sends application to the College for assessment.

Overseas-trained surgeon with permanent residency – sponsored by spouse.

Medicare: The Commonwealth has imposed a 10 year moratorium on granting Medicare provider numbers to overseas-trained practitioners. Exemptions are only available if doctors agree to work where there is a shortage of doctors (ie an area-of-need position).

Salaried position in a public hospital.
3. **AUSTRALIAN SURGEONS – A STATISTICAL OVERVIEW**

**Number of surgeons**

3.1 In 1998, the Australian specialist workforce comprised 16 490 doctors of whom 2 937 were surgical specialists. This represents an increase of 229 surgeons across Australia from 2 708 in 1996.\(^{56}\) General and orthopaedic surgeons account for 60% of the workforce. In 1998, the number of practitioners in the different surgical subspeciality areas in Australia were:

<table>
<thead>
<tr>
<th>Surgical Sub-specialty</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>1028</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>97</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>102</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>714</td>
</tr>
<tr>
<td>Otolaryngology – head and neck surgery</td>
<td>302</td>
</tr>
<tr>
<td>Paediatric surgery</td>
<td>77</td>
</tr>
<tr>
<td>Urology</td>
<td>222</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>140</td>
</tr>
<tr>
<td>Plastic and reconstructive surgery</td>
<td>256</td>
</tr>
</tbody>
</table>

3.2 As at December 1998, there were 15.6 surgeons per 100 000 persons, which represents a total increase of 0.9 surgeons per 100 000 persons, from 14.7 surgeons per 100 000 persons in 1996.\(^{58}\)

---


\(^{58}\) AIHW *Medical Labour Force 1998*, Table 54 (supplementary tables).
3.3 As at December 1998, the number of surgeons in each state and territory were:

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Number in each state and territory</th>
<th>Number of surgeons per 100 000 population in each state and territory</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>996</td>
<td>15.6</td>
</tr>
<tr>
<td>Victoria</td>
<td>808</td>
<td>17.2</td>
</tr>
<tr>
<td>Queensland</td>
<td>471</td>
<td>13.5</td>
</tr>
<tr>
<td>South Australia</td>
<td>280</td>
<td>18.8</td>
</tr>
<tr>
<td>Western Australia</td>
<td>254</td>
<td>13.7</td>
</tr>
<tr>
<td>Tasmania</td>
<td>57</td>
<td>12.1</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>21</td>
<td>10.8</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>52</td>
<td>16.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2708</strong></td>
<td></td>
</tr>
</tbody>
</table>

As at 1998, the number of surgeons per 100 000 population in Australia for each sub-speciality was as set out in Table 3.3.

<table>
<thead>
<tr>
<th>Sub-specialty</th>
<th>Surgical specialist per 100 000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>5.5</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>0.5</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0.5</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>3.8</td>
</tr>
<tr>
<td>Otolaryngology – head and neck surgery</td>
<td>1.6</td>
</tr>
<tr>
<td>Paediatric surgery</td>
<td>0.4</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>1.4</td>
</tr>
<tr>
<td>Urology</td>
<td>1.2</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>0.7</td>
</tr>
</tbody>
</table>

3.4 As at 1998, the number of surgeons per 100 000 population in Australia for each sub-speciality was as set out in Table 3.3.

3.5 In 1998 the number of surgeons in each of the different surgical sub-speciality areas by state and territory were:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>SA</th>
<th>WA</th>
<th>TAS</th>
<th>NT</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>358</td>
<td>288</td>
<td>180</td>
<td>88</td>
<td>75</td>
<td>17</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>32</td>
<td>33</td>
<td>15</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>35</td>
<td>28</td>
<td>11</td>
<td>14</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>242</td>
<td>170</td>
<td>119</td>
<td>87</td>
<td>69</td>
<td>11</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Otolaryngology – head and neck surgery</td>
<td>99</td>
<td>79</td>
<td>49</td>
<td>24</td>
<td>36</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Paediatric surgery</td>
<td>25</td>
<td>23</td>
<td>9</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>77</td>
<td>82</td>
<td>30</td>
<td>28</td>
<td>26</td>
<td>7</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Urology</td>
<td>72</td>
<td>62</td>
<td>36</td>
<td>19</td>
<td>21</td>
<td>9</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>57</td>
<td>43</td>
<td>22</td>
<td>6</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

**Change in number of surgeons in each sub-specialty between 1996 and 1998**

3.6 Between 1996 and 1998, the number of surgeons per 100 000 persons increased slightly in four surgical sub-specialties. In particular, the number of surgeons per 100 000 persons:

- increased by 0.6% in general surgery (from 4.9 to 5.5 surgeons per 100 000 persons);
- remained the same in cardiothoracic surgery (at 0.5 surgeons per 100 000 persons);
- decreased by 0.1% in neurosurgery (from 0.6 to 0.5 surgeons per 100 000 persons);
- increased by 0.2% in orthopaedic surgery (from 3.6 to 3.8 surgeons per 100 000 persons);
- decreased by 0.1% in otolaryngology – head and neck surgery (from 1.7 to 1.6 surgeons per 100 000 persons);
- remained the same in paediatric surgery (at 0.4 surgeons per 100 000 persons);
- increased by 0.2% in plastic surgery (from 1.2 to 1.4 surgeons per 100 000 persons);
- increased by 0.1% in urology (from 1.1 to 1.2 surgeons per 100 000 persons); and
- remained the same in vascular surgery (at 0.7 surgeons per 100 000).62

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Gender distribution of surgeons

3.7 In 1998, 96% of surgeons in Australia were male. The number of male surgeons increased from 2,613 in 1996 to 2,832 in 1998. Over the same period, the number of female surgeons increased from 95 in 1996 to 106 in 1998.\(^6^3\)

3.8 Generally, the Australian Institute of Health and Welfare (AIHW) indicated in its 1998 Medical Labour Force Survey that female medical students are much more likely than males to choose general practice as a career path and less likely to select speciality practice, especially surgery.\(^6^4\)

3.9 In 1998, the number of male and female surgeons per surgical sub-speciality were:

<table>
<thead>
<tr>
<th>Surgical sub-speciality</th>
<th>Male</th>
<th>Female</th>
<th>Proportion of female surgeons</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>991</td>
<td>37</td>
<td>4%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>92</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>93</td>
<td>8</td>
<td>8%</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>706</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>Otolaryngology – head and neck surgery</td>
<td>289</td>
<td>13</td>
<td>4%</td>
</tr>
<tr>
<td>Paediatric surgery</td>
<td>68</td>
<td>9</td>
<td>12%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>241</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>Urology</td>
<td>217</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>135</td>
<td>5</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2832</strong></td>
<td><strong>106</strong></td>
<td></td>
</tr>
</tbody>
</table>

Hours worked by surgeons

3.10 In 1998, the highest proportion of doctors working 80 hours or more per week were surgeons (14.9%).\(^6^6\) In addition, approximately 17% of surgeons were working between 65-79 hours per week.

3.11 Table 3.6 shows the weekly hours worked by surgeons.

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\(^{63}\) Figures compiled from: AIHW, Medical Labour Force 1998, Table 17, p26; AIHW, Medical Labour Force 1996, Table 7, p12.

\(^{64}\) AIHW, Medical Labour Force 1998, p5.

\(^{65}\) AIHW, Medical Labour Force 1998, Table 17, p26.

Table 3.6: Hours worked by surgeons per week

<table>
<thead>
<tr>
<th>Hours per week</th>
<th>Proportion of surgeons (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-19</td>
<td>5</td>
</tr>
<tr>
<td>20-34</td>
<td>7</td>
</tr>
<tr>
<td>35-49</td>
<td>19</td>
</tr>
<tr>
<td>50-64</td>
<td>37</td>
</tr>
<tr>
<td>65-79</td>
<td>17</td>
</tr>
<tr>
<td>80 or more</td>
<td>15</td>
</tr>
</tbody>
</table>

In 1998, 16.8% of male surgeons worked between 65-79 hours per week, while 14.7% of female surgeons worked between the same hours. In addition, 15% of male surgeons worked 80 or more hours per week, compared to 12.9% of female surgeons.

Table 3.7 below surgeons’ weekly hours by sub-specialty. The Table indicates that the surgical sub-specialties where more than 30% of practitioners reported working more than 65 hours per week were general surgery, cardiothoracic surgery, neurosurgery, orthopaedic surgery, paediatric surgery, urology and vascular surgery.

Table 3.7: Weekly hours by surgical sub-specialty in 1998

<table>
<thead>
<tr>
<th>Surgical sub-specialty</th>
<th>Total hours worked per week</th>
<th>% of surgeons working more than 65 hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-19</td>
<td>20-34</td>
</tr>
<tr>
<td>General surgery</td>
<td>70</td>
<td>56</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>31</td>
<td>70</td>
</tr>
<tr>
<td>Otolaryngology – head and neck surgery</td>
<td>18</td>
<td>29</td>
</tr>
<tr>
<td>Paediatric surgery</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

---

68 AIHW, Medical Labour Force 1998, Table 9, p19.
69 AIHW, Medical Labour Force 1998, Table 64 (supplementary tables).
Table 3.7: Weekly hours by surgical sub-specialty in 1998

<table>
<thead>
<tr>
<th>Surgical sub-specialty</th>
<th>Total hours worked per week</th>
<th>% of surgeons working more than 65 hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-19</td>
<td>20-34</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Urology</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

Age of surgeons

3.14 In 1998, the highest number of surgeons were in the 45-54 year age group. Table 3.8 shows the age profile of surgeons in 1998.

Table 3.8: Age of surgeons in 1998

<table>
<thead>
<tr>
<th>Age</th>
<th>Proportion of surgeons (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 35 years</td>
<td>2</td>
</tr>
<tr>
<td>35-44 years</td>
<td>25</td>
</tr>
<tr>
<td>45-54 years</td>
<td>31</td>
</tr>
<tr>
<td>55-64 years</td>
<td>28</td>
</tr>
<tr>
<td>65-74 years</td>
<td>12</td>
</tr>
<tr>
<td>More than 75 years</td>
<td>2</td>
</tr>
</tbody>
</table>

70 Figures compiled from: AIHW, Medical Labour Force 1998, Table 63 (supplementary tables).
4. HISTORY OF SURGICAL TRAINING IN AUSTRALIA

Origins of the College

4.1 In the 1920s – as is the case today, except South Australia and Queensland – there was no direct statutory restriction on who may perform surgery other than that they be registered as a medical practitioner under state or territory legislation.

4.2 Moreover, universities awarded (and still generally award) medical undergraduates a Bachelor of Medicine and a Bachelor of Surgery and it appears that many general practitioners (perhaps not surprisingly) considered that the latter entitled them to operate. The only ways for a specialist surgeon to formally distinguish him or herself from a general practitioner was to become a fellow of one of the British, Irish or American surgical colleges or obtain a higher university surgical degree. Probably for obvious geographical reasons, many if not most surgeons did not or could not take up the former option.

4.3 Specialist surgeons of the time consequently became concerned about:

- a growing disregard by younger practitioners of recognised ethics of Surgical Practice, combined with a spirit of commercialism tending to degrade the high traditions of the surgical profession.
- Difficult and dangerous operations are undertaken by practitioners who have not been properly trained in surgical principles and practice, and who divide fees with colleagues who refer the patients to them. They also operate in small and inadequately equipped hospitals which have recently sprung into existence in large numbers. The public has no means of judging the competency of these so-called surgeons… and the efficiency of these hospitals. It is felt that steps should be taken to counteract these conditions.
- It is proposed that a body should be formed which would have authority to indicate that its members were properly qualified to practise surgery and its various specialties, and to hold positions as such on hospital staffs.
- It is suggested that Senior Surgeons and Surgical Specialists, who could not be regarded as having any personal ends in view, should initiate such a body. Its objects would be to endeavour to raise the status of surgery and check its practice by those who are not adequately trained, and also to improve hospital standards.

4.4 However, the formation of an exclusive surgical college was generally opposed by the general practitioners who dominated the medical profession for two reasons: (i) that those supporting the college were ‘creating a self-appointed aristocracy of surgeons

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71 The Royal College of Surgeons of England, the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow, the Royal College of Surgeons of Ireland and the American College of Surgeons. American Fellowships were rare.

72 Of the 41 Founders of the College, only 13 had English Fellowships, with one Irish Fellowship and one from the Edinburgh College; The Mantle of Surgery – The First Seventy-Five Years of the Royal Australasian College of Surgeons, A.W. Beasley, published by the Royal Australasian College of Surgeons, 2002, p53.

73 Extract from letter from G.A Syme, Hamilton Russell and H.B Devine to surgeons in Australian and New Zealand, 19 November 1925, ibid, p18. It appears that the authors of the letter considered that senior surgeons and surgical specialists would not be regarded as having any personal interest in the establishment of the College because they were aged; ibid, p54.
and destroying the livelihood of many who would be excluded’; and (ii) a new college would threaten the unity of the then British Medical Association.\textsuperscript{74}

4.5 However, in 1927, the College was formed. Fellowship was initially open to surgeons who possessed at least five years of post-graduate training and (from 1932) a senior surgical degree or diploma.\textsuperscript{75} Post-graduate training soon effectively meant an apprenticeship to a senior surgeon, although other work (e.g. research) was recognised.\textsuperscript{76}

4.6 These entry requirements combined the approaches of the American College of Surgeons and the British and Irish surgical colleges. The former relied primarily on post-graduate training, in the belief that surgical competency was best determined by assessing a surgeon’s record of operations. The latter colleges relied on higher surgical degrees to do this.\textsuperscript{77}

**Accreditation of hospital posts**

4.7 While the College recognised from its earliest days the need to improve hospital standards so as to improve training standards, it was not until the mid-1940s that it made significant progress in this area, and not until the early 1960s that a systematic inspection and approval system for hospital posts was established.\textsuperscript{78} Hospital post inspections became more important with the introduction of structured training programs from the 1970s in the various surgical sub-specialties that had developed in the previous decades.\textsuperscript{79}

4.8 The College’s current system for accrediting hospitals and hospital posts is detailed at paragraphs 6.82- 6.105.

4.9 A problem that emerged in response to the College’s 1940’s initiatives to commence accrediting hospital posts for training purposes was that nearly all posts in Sydney hospitals were at that stage part of the University of Sydney’s Master of Surgery degree (which included an apprenticeship requirement). However, this resistance was, for some reason, brief.\textsuperscript{80}

**Examinations**

4.10 Upon the establishment of the College, surgeons were only required to provide documentary evidence of their training to a credentialing committee which assessed its adequacy. From 1934, surgeons who had completed their post-graduate training were interviewed by a board of censors to test their knowledge and ability. From 1946, the College replaced this interview with an exit examination – which evolved


\textsuperscript{75} The Mantle of Surgery, op. cit, p56. Higher surgical degrees included a Master of Surgery from an Australasian university; ibid, p86. See also The Shaping of the RACS 1920-1960, op.cit n.64, p17.

\textsuperscript{76} The Mantle of Surgery, op cit, p56.

\textsuperscript{77} Ibid, p55-56.

\textsuperscript{78} The Shaping of the RACS 1920-1960, op.cit, pp17-18, 40, 42.

\textsuperscript{79} The Mantle of Surgery, op. cit, p152.

\textsuperscript{80} The Shaping of the RACS 1920-1960, op.cit. pp40-41.
into today’s Part 2 exam taken in the final year of advanced surgical training (see paragraph 6.71). 81

4.11 As indicated above, applicants for College Fellowship were also required to possess a senior surgical degree. Between 1931 and 1946, the Royal College of Surgeons of England periodically conducted its Fellowship exam in Australia and passing this exam satisfied the surgical degree requirement, in addition to actually completing a senior surgical degree at an Australian university. 82 Indeed, the University of Sydney refused to co-operate with the English college, whom it considered a competitor. 83

4.12 From 1949, the College decided that it could no longer rely on qualifications awarded by other bodies whose standard it could not guarantee. It therefore required prospective surgeons to pass its own entry examination – which evolved into today’s Part 1 exam taken in the second year of basic surgical training. This displaced the English Fellowship and the Australian senior surgical degrees (which became research degrees). 84 In 2000, the College introduced a structured Basic Surgical Training program which included the Part 1 exam (see paragraph 6.21).

The College becomes dominant

4.13 At the end of the College’s first quarter-century of existence, many surgeons were not College Fellows. For example, in 1955 in Queensland, 38 surgeons under the age of 50 possessed the English Fellowship and only 17 the Australasian. 85 In particular, the requirement to sit the Part 2 examination was a significant disincentive to seeking Fellowship for many established surgeons, as it was for newer surgeons returning from England with the English Fellowship (which was by then effectively competing with the College in the field of surgical qualification).

4.14 During the 1950s, the College temporarily relaxed this requirement in various ways so as to attract these surgeons into the College. While being criticised at the time for indecision about standards, this relaxation appeared to largely succeed in achieving its immediate goal and, in the longer term, helped to establish the College’s dominance in Australia. In 1992, the College decreed that its Fellowship would be the only valid surgical diploma in Australasia. 86

81 The Mantle of Surgery, op. cit pp56, 86.
82 Ibid, pp59-60, 86-87; The Shaping of the RACS 1920-1960, op cit, p23. It appears the motive of the English college in offering to conduct its Primary exam in Australia was to ward off the influence of the American college.
84 The Mantle of Surgery, op cit, p87; The Shaping of the RACS 1920-1960, op cit, p29.
85 The Mantle of Surgery, op. cit, p88; The Shaping of the RACS 1920-1960, op cit, p27.
86 The Mantle of Surgery, op. cit, Chapter 6 and p241. See also The Shaping of the RACS 1920-1960, op cit, pp29-30, 35-37.
5. **THE COLLEGE**

5.1 The College is an Australian public company limited by guarantee. It was established in 1927 and incorporated in 1930 in Melbourne, Victoria.

5.2 The objectives of the College are:

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

**Structure and management of the College**

*The Council*

5.3 The governing body of the College is a Council of:

- 16 Fellows who are elected to the Council for a period of three years and who are eligible for re-election at the end of those three years; and
- nine co-opted Fellows who represent specialty societies and other interests. Each of the geographic regions and surgical sub-specialties is represented on the Council.

5.4 The Council Executive is elected annually by the members of the Council and comprises the President, Vice President, Honorary Treasurer, Censor-in-Chief, and Chairmen of the Court of Examiners and Board of Basic Surgical Training.

5.5 The Council has the power under the College’s Memorandum and Articles of Association to make rules and regulations in relation to a number of matters including:

- the admission by examination of persons as Fellows of the College;
- the election of persons as Honorary Fellows of the College;
- the creation and maintenance of faculties, divisions, sections and other groupings within the College;
- the promulgation of the duties and functions of all persons in the employ of the College;
- the creation, appointment, direction and dissolution of committees;
- the maintenance and amendment from time to time of the register of Fellows;
the discipline, suspension and expulsion of Fellows and other procedures (including imposing any penalties or fines) as is necessary to uphold the ethics, dignity, good reputation, standards and purposes of the College; and

the procedures for the hearing of any appeal or review of any decision of a Complaints Committee Council (Regional or Complaints Committee), including the establishment of special committees for that purpose, proceedings at and conduct of meetings for that purpose, and any other incidental procedures or matters.

5.6 The management of the College is overseen by the Chief Executive, who is responsible for advising the Council and providing the management infrastructure to ensure that policy decisions can be implemented without the direct involvement of Fellows.

Committees

5.7 The College has established a range of committees and boards to assist it to perform its functions. Committees and boards relevant to its application for authorisation are set out in Table 5.1 below. An overview of the College’s structure is also provided in Table 5.1 below.

<table>
<thead>
<tr>
<th>Committee</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Committee of Council</td>
<td>Reports directly to and acts for the Council between meetings. It has the power to deal with all issues. With limited exceptions, other committees report to the Council through the Executive Committee.</td>
</tr>
<tr>
<td>Education Policy Board (EPB)</td>
<td>The EPB is the senior, overarching education policy forum. The Board of Basic Surgical Training, Board of Advanced Surgical Training and the Court of Examiners fall under it.</td>
</tr>
<tr>
<td>Board of Basic Surgical Training (BBST)</td>
<td>Responsible for all activities affecting the selection, education and training and examination of Basic Trainees. Regional sub-committees act as BBST’s local agent regarding the selection and training of basic trainees. Sub-committees also report to the BBST on the three basic trainee skills courses (see paragraph 6.21) and each of the various examinations for basic trainees (see paragraphs 6.31-6.34).</td>
</tr>
</tbody>
</table>

87 Table compiled from the College’s supporting submission to the application for authorisation, 30 March 2001, (Attachment 1).
Board of Advanced Surgical Training (BAST) (formerly the Censor-in-Chief’s Committee) | Responsible for all activities affecting the selection, training and examination of advanced trainees in consultation with Specialty Boards and the BBST.

Speciality Boards | All nine surgical specialty boards report through and have representation on the BAST. Each of these Boards have Regional Sub-Committees.

Court of Examiners | Reports to and has representation on the Education Policy Board but may inform Council directly of the Part II examination results. The Court of Examiners consists of examiners from each of the surgical sub-specialities. The role of the Court of Examiners is to organise, conduct and advise on the format of the Part II Examination in the relevant surgical discipline.

**College Fellows**

5.8 In February 2002, the AMC reported that there were 5176 Fellows of the College, of which 4053 reside in Australia and 661 in New Zealand. Approximately 90% of surgeons practising in Australia and New Zealand are Fellows of the College.88

**Affiliated societies**

5.9 The College has established specialty boards in all surgical subspecialties. These specialty boards are responsible for significant elements of the College’s training and assessment processes, including:

- determining the content, structure and duration of advanced surgical training;
- the accreditation of advanced surgical training posts;
- the selection of advanced surgical trainees; and
- the assessment of advanced surgical trainees, including their eligibility to sit the Part 2 examination.

5.10 However, the Commission understands that, for the following surgical sub-specialties, the members of the College specialty board are largely nominated by the relevant affiliated surgical society (listed in Figure 5.1 below):

- orthopaedic surgery;
- urology;
- otolaryngology – head and neck surgery;
- neurosurgery; and
- paediatric surgery.

5.11 Effectively, the College has delegated the responsibilities of the specialty board to the relevant surgical society. The Commission understands that surgical societies also influence the appointment of Fellows to the College’s Court of Examiners, which controls the Part 2 exam, as well as the format and content of this exam.

5.12 The Commission also understands that, in the surgical sub-specialties listed above:

- the relevant surgical society has established a training, accreditation and education committee to oversee the responsibilities delegated to it; and
- this committee typically comprises the persons nominated by the surgical society to the College specialty board.
Figure 5.1: Overview of the structure of the College\textsuperscript{89}

\textsuperscript{89} Compiled by the Commission from the College’s supporting submission to the application for authorisation, March 2001, Attachment 1.
6. THE COLLEGE’S SURGICAL TRAINING PROGRAM AND PROCESS FOR ASSESSING
OVERSEAS-TRAINED SURGEONS

6.1 The College seeks authorisation of its activities with respect to:

- selecting, training and examining basic surgical trainees;
- selecting, training and examining advanced surgical trainees in all nine surgical sub-specialities;
- accrediting hospitals for basic surgical training and hospital training posts for advanced surgical training; and
- assessing the qualifications of overseas-trained surgeons.

6.2 The application for authorisation is made on behalf of:

- the College, its officers, employees, current Fellows, as well as the current members of the College’s affiliated specialist societies and associations; and
- pursuant to section 88(10), all future College Fellows, as well as future members of the College’s affiliated specialist societies and associations.

6.3 The College is seeking authorisation under the State and Territory Competition Codes, as well as the Act.90

6.4 The College’s application, including a list of the specialist societies on whose behalf the application is made, is at Attachment A.

6.5 The College is seeking authorisation to give effect to a contract, arrangement or understanding, a provision of which has the purpose, or has or may have the effect, of substantially lessening competition within the meaning of section 45 of the Act.

The selection, training and examination of trainees

6.6 The College offers basic surgical training (covering surgical theory and practice common to all surgical sub-specialties) and advanced surgical training. Advanced surgical training is offered in the areas of general surgery, cardiothoracic surgery, neurosurgery, orthopaedic surgery, otolaryngology – head and neck surgery, paediatric surgery, plastic and reconstructive surgery, urological surgery and vascular surgery.

6.7 College Fellows working primarily in public hospitals provide surgical training. The College has complete control over trainee examinations, but it depends on the cooperation of hospitals to ensure adequate training.

6.8 Trainees move through a minimum of two years of basic surgical training and a minimum of four years of advanced surgical training in the relevant nominated surgical specialty. Surgical training becomes increasingly complex as trainees progress through the program. Trainees are supervised by College Fellows and training takes place either at College accredited hospitals (basic training) or in College-accredited hospital posts (advanced training).

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The stated objective of the College’s selection, training and examination program is to ensure that trainees develop the necessary knowledge, skills and attitude to become a:

- medical expert;
- communicator with patients and their families;
- collaborator with other medical practitioners and health care professionals;
- manager of personal resources;
- health advocate;
- scholar and teacher; and
- health care professional.

**Selection of trainees for basic surgical training**

6.10 Applicants for the basic surgical training program must possess a MB BS (Bachelor of Medicine and Bachelor of Surgery) or equivalent and be registrable in Australia and New Zealand. That is, the applicant must have attended a medical school which has received accreditation from the AMC and have one year of post graduate experience (internship). Trainees usually apply to the College for admission to the program during their first year in an internship.

6.11 Until the 2001 intake, the number of trainees accepted into the College’s basic training program was unlimited. Any junior doctor in any hospital with an interest in a surgical career could apply for the basic training program. However, with the introduction of the restructured training program from 2000, basic surgical training places are only available to qualified applicants who obtain a position in an accredited hospital. The final intake into the old basic surgical training program was in 2000, a condition of entry being that trainees complete training by the end of 2003.

6.12 Under the new program, applicants are required to apply simultaneously to the College for a place in the basic training program and to an accredited hospital (or hospital authority) for a hospital training post. The appropriate hospital authority makes the appointment to a hospital. The Hospital Supervisor of Basic Surgical Training is normally a member of the hospital selection committee.

6.13 Applicants are selected by the relevant Regional Sub-Committee of the Board of Basic Surgical Training of the College on the basis of:

- a structured curriculum vitae;
- their performance at a semi-structured interview; and
- referee reports.

6.14 The Regional Sub-Committee determines a score for performance in each of the individual components listed above. For example, when assessing a curriculum vitae the Regional Sub-Committee may score a university prize received by the applicant or evidence of research conducted by the applicant highly. Applicants are ranked according to the total of weighted scores in each of the above components. Members of the interview selection panel do not have access to the applicant’s score from their curriculum vitae or referee reports.

6.15 The College establishes a cut off-point by deciding what an acceptable overall score would be. Applicants scoring above this are then ranked nationally. Positions are
offered in order of merit until all available positions in accredited hospitals are filled. Applicants are made aware of the selection tools used in the selection process, but are not advised of the individual scoring of each component or the weighting of each which culminates in the overall score.

6.16 For the 2002 intake, the number of basic surgical trainees selected was limited to 180. The Commission understands that this limit reflects:

- the availability of places in the three basic training skills courses (detailed in paragraph 6.26), which is dependent on the number of trainers from the College; and
- the number of advanced surgical training places likely to be available when the successful applicants complete basic surgical training.

**Interviews**

6.17 The College has developed an interview pro-forma which is followed for each applicant. The interview runs for approximately 20 minutes and consists of three questions which address the following key attributes:

- motivation (including surgical goals, self-evaluation, training and organisation);
- medical ethics;
- conflict; and
- communication.

6.18 At the conclusion of the selection interview, each interviewer completes an individual rating form which records the applicant’s score for each attribute. The interview panel then reaches a consensus rating for each of the key attributes on a panel rating form. The process of reaching a consensus commences with both interviewers reading out their comments for each attribute, followed by the numerical score they have given. The interviewers then must reach an agreed score. An average of the two scores is not an acceptable method to achieve the consensus score. If a consensus cannot be reached, even after recalling the applicant, arrangements are made for a new panel to re-interview the applicant as soon as possible. The panel rating form is the official record of the interview, and is provided to the Regional Sub-committee for consideration. The comments and scores on the individual rating forms, which must not be altered after consensus is reached, are used as quality assurance data for the interview process.

**Successful applicants**

6.19 If an applicant is selected for the basic surgical program, and the applicant is successful in obtaining an accredited hospital post, they must register with the College as a basic surgical trainee. Trainees are required to re-register with the College each year. Re-registration is subject to satisfactory in-training assessment reports (see paragraph 6.29), and if necessary, the trainee will be re-interviewed. A trainee is eligible to remain registered:

- for a maximum of the equivalent of four years basic surgical training; or

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91 Royal Australasian College of Surgeons, Interviews August 2001 – Notes for Interviewers.
• for a maximum of four attempts at the Part 1 (Basic Surgical Training) Examination (discussed at paragraph 6.31 below), whichever occurs sooner.

6.20 In relation to the registration period, the College submits that four attempts at the Part 1 (Basic Surgical Training) Examination or a maximum of three attempts to gain an Advanced Surgical Training place provides trainees with sufficient opportunities to demonstrate their credentials for gaining an Advanced Surgical Training place.92

Training of basic surgical trainees

6.21 The duration of basic surgical training is a minimum of two years and a maximum of four years. Over this period, trainees acquire knowledge of the theory and practice of surgery in areas common to all branches of surgery. The program is comprised of four components:

• clinical experience;
• distance learning;
• skills courses; and
• assessment and examinations.

6.22 Basic trainees are able to undertake part-time or interrupted training (for example to undertake research, for ill-health or for parenting) at any time during basic training.93

Clinical experience

6.23 The basic surgical training program may be described as an ‘apprenticeship’, the practical aspect of which takes place in a post in an accredited hospital and involves one to one relationships between the trainee and College Fellows throughout the program. Trainees normally rotate through a series of training posts, each of approximately three months in length, in order to gain exposure to as many surgical sub-specialties and related disciplines as possible.

6.24 Trainees are required to occupy approved surgical posts for a minimum period of 12 months (that is, four rotations). For the remaining 12 months, trainees must spend at least three months in an emergency department, and a minimum of two months in a general intensive care or high dependency unit that is supervised by a qualified surgeon, anaesthetist or intensivist. The balance may be spent in surgical, medical or basic science posts, or in approved research projects.

Distance learning

6.25 Basic surgical trainees must also complete a Distance Learning Program, consisting of 22 education modules. The education program is coordinated through the College’s basic surgical training on-line website. The program is based on the application of the basic sciences to clinical practice. Trainees are also required to cover a comprehensive recommended reading list.

Skills courses

6.26 Basic surgical trainees are required to complete three skills courses. These are:

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93 College submission to the Australian Medical Council for Accreditation, May 2001, p22.
- the Basic Surgical Skills course undertaken during the first six months of the training program. The course is designed to give the trainee the opportunity to practise skills such as suturing under close supervision. Courses are conducted in each State;
- the Early Management of Severe Trauma course completed during the first year of training. This is an intensive course in the management of trauma victims in the first one to two hours following injury. It entails two and a half days of structured teaching with opportunities for development and practice of necessary skills; and
- the Care of the Critically Ill Surgical Patients course undertaken in the first six months of the second year of the program. This course is designed to advance the practical, theoretical and personal skills necessary for the care of critically ill surgical patients. It involves three days of instruction and experience, partly using simulators to demonstrate priorities for treatment of surgical patients.

6.27 Trainees are also expected to participate in a range of hospital resident training programs including demonstrations, discussions and seminars on basic surgical sciences, clinical meetings, and audit review within the hospital.

Assessment and examination of basic surgical trainees

6.28 In addition to successfully completing the distance learning program and skills courses, basic surgical trainees must also pass the Part 1 Basic Training Exam. The performance of basic trainees is also assessed via continuous clinical in-training assessment reports.

In-training assessment reports

6.29 Trainees’ surgical supervisors prepare continuous clinical in-training assessment reports of their performance in each rotation they undertake. Where a trainee has several supervisors, each supervisor may prepare an assessment report. The Hospital Supervisor of Surgical Training then amalgamates the assessments to produce a single in-training assessment report for the trainee. Alternatively, supervisors may discuss the trainee’s performance with the Hospital Supervisor of Surgical Training, who writes a single assessment report. The aim of the reports is to monitor the performance of basic trainees across a range of professional activities, namely:

- Clinical skills – assessment of history, use of investigations, judgement and post-operative care;
- Technical skills – surgical laparoscopy/endoscopy, open surgery as a surgical assistant;
- Academic performance – knowledge of subject, case presentations, learning and teaching;
- Attitudes – communication with patients, cooperation with staff, self motivation and organisation, reliability and punctuality, stress responses, acceptance of criticism; and
- Research – research can be credited towards surgical training.

6.30 The trainee receives a rating from their supervisor in each activity, ranging from poor to excellent. The trainee must receive scores of 3 (satisfactory) or better in each activity. An overall rating is then assigned. A minimum of 52 weeks of satisfactory assessment must be achieved during basic surgical training. Further training is required if a trainee fails to meet this requirement.
Part 1 Basic Training Examination

6.31 The Part 1 Basic Training Examination package is designed to ensure that the basic surgical trainee, regardless of the intended surgical specialty, has acquired the knowledge of the scientific foundations of surgery. The examination is overseen by the Board of Basic Surgical Training. Trainees are only eligible to sit the Part 1 Examination in the second year of the basic surgical program, and after completing the distance learning component of the program.

6.32 Specifically, the Part 1 Examination consists of:

- The Multiple Choice Questions Examination consisting of three papers, each having 120 multiple choice questions to be completed within two and a half hours. These questions are drawn from the disciplines of anatomy, physiology and pathology. A trainee is required to obtain a minimum standard in each of the three disciplines, at the same sitting, before a trainee is deemed to have passed the multiple choice examination; and

- The Objective Structured Clinical Examination consisting of 20 ‘stations’ at which the trainee spends five minutes undertaking tasks that may include:
  - history taking and examinations;
  - demonstration of practical technical skills;
  - the application of basic science knowledge; and
  - data acquisition and analysis.

6.33 The Part 1 Multiple Choice Examination is held in February/March, June/July and October/November each year in all Australian capital cities except Canberra and Darwin, as well as, subject to sufficient numbers, Auckland, Wellington, Christchurch, Dunedin, Singapore, Kuala Lumpur and Hong Kong. The pass rate of the Part 1 Multiple Choice Examination from 1995 to 2000 is provided in Table 6.3.

6.34 Also subject to there being a sufficient number of candidates, the Objective Structured Clinical Assessment is held in February/March and June/July each year. The pass rate of the Part 1 Structured Clinical Examination from 1995 to 2000 is provided in Table 6.4.

Basic surgical training experience portfolio

6.35 The trainee is also required to complete a basic surgical training experience portfolio for each rotation to record the breadth and depth of hospital training, as well as the number and type of procedures undertaken by the trainee. The portfolios are forwarded to the College at the conclusion of each rotation. The Commission understands that trainee portfolios do not form part of a trainee’s assessment. Rather, they are collected by the College to evaluate the basic surgical program and to identify any trends arising from trainee progression and hospital experiences.

6.36 The portfolios contain basic demographic data and information about each of the following elements of training:

- Basic Surgical Training Program, including access to supervisors and education modules;
- ambulatory care experience;
- operative experience;
• procedural experience;
• operative/procedural log;
• in-patient management experience which includes breaking bad news and the management of dying patients;
• academic activity;
• courses attended;
• teaching involvement; and
• personal growth.

Intermediate years

6.37 As previously discussed, basic surgical trainees have a minimum of two years and a maximum of four years to complete the basic training program. During this time they remain in hospitals accredited for the purposes of basic training. After successfully completing basic surgical training, a trainee selects an area of surgery in which they wish to specialise. A basic surgical trainee must then win a place in the relevant advanced surgical training program. Applications for advanced surgical training will only be accepted from registered trainees.

6.38 The Commission understands that traditionally a significant proportion of trainees who complete basic surgical training were not immediately successful in obtaining a place in advanced training. These trainees continued in non-accredited hospital posts until they won an advanced training position (or exited from surgical training).

6.39 For 2001, Table 6.6 shows the average number of months since trainees completed basic surgical training, per surgical sub-speciality, before they were accepted into advanced surgical training.

6.40 The Commission understands that a key aim of the new basic surgical training program – which aligns the number of basic surgical trainees with the number of advanced surgical training positions expected to exist when they finish – is to ensure a smooth transition for basic surgical trainees to advanced surgical training.

Selection of trainees for advanced surgical training

Selection process

6.41 Appointments to the advanced surgical training program are made either through a national selection committee or a regional sub-committee of the relevant Specialty Board (or affiliated surgical association) of the College. The Commission understands that all surgical specialties were to have a national selection process in place by 2002. The selection committee varies with each Board, but the College has advised that ideally there should be representatives from the College and the relevant training hospital, usually the hospital medical superintendent.

6.42 The same selection tools are used in the selection of trainees across the nine surgical sub-specialties, namely:

• structured curriculum vitae;
• referee reports; and
• semi-structured interview.
6.43 Pre-determined components of each of the above selection tools are scored and tallied. The Commission understands that each sub-speciality assigns its own weighting to these components. A nationally ranked list of applicants is prepared in each area of surgery (and a State listing for those specialities which have not yet adopted an Australia–wide selection process). A case study demonstrating the selection processes adopted by the Australian Orthopaedic Association is provided below.

6.44 Offers in each sub-speciality are then made to applicants in order of merit until either:

- the pre-determined minimum standard for qualified candidates is reached; or
- all available posts are filled.

6.45 Trainees who are unsuccessful in obtaining a position in their preferred advanced surgical training program are advised in writing that feedback and counsel is available. The Commission understands that there is some variation across the specialities as to how this is done, some as face to face interviews others by phone.

6.46 As an example, an overview for the 2001 advanced surgical training application process for general surgery is provided in Table 6.1 below.

<table>
<thead>
<tr>
<th align="left"><strong>Table 6.1: Overview of the advanced general surgical application process for 2001</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td align="left"><strong>Closing date for applications.</strong></td>
</tr>
<tr>
<td align="left"><strong>Acknowledged receipt of application letters.</strong></td>
</tr>
<tr>
<td align="left"><strong>Referee reports sought.</strong></td>
</tr>
<tr>
<td align="left"><strong>Referee reports due back.</strong></td>
</tr>
<tr>
<td align="left"><strong>Referee reports not received sought.</strong></td>
</tr>
<tr>
<td align="left"><strong>Part 1 Basic Training Examination results available.</strong></td>
</tr>
<tr>
<td align="left"><strong>Eligible applicant details distributed to States for interviews to be arranged.</strong></td>
</tr>
<tr>
<td align="left"><strong>Ineligible applicants notified.</strong></td>
</tr>
<tr>
<td align="left"><strong>Interviews to be held.</strong></td>
</tr>
<tr>
<td align="left"><strong>Final date for interviews.</strong></td>
</tr>
<tr>
<td align="left"><strong>Board Selection Meeting/Teleconference.</strong></td>
</tr>
<tr>
<td align="left"><strong>First round offers made.</strong></td>
</tr>
<tr>
<td align="left"><strong>Acceptance of positions to be returned.</strong></td>
</tr>
</tbody>
</table>
6.47 As with the selection of basic surgical trainees, an interview pro-forma is followed for each applicant for advanced surgical training. The interview generally consists of six questions which relate to the following attributes:

- the ability to interact effectively and affably with peers, mentors, members of the health care team, patients and their families;
- the ability to contribute as a member of a health care team;
- the ability to act ethically, responsibly and with honesty;
- the ability to perform realistic self-assessment;
- a capacity for caring, concern and sensitivity to the needs of others; and
- effective spoken communication.

6.48 The process for scoring and reaching consensus on the trainee’s performance at the interview is the same as that for the selection of trainees for basic surgical training. The interview panel is issued with criterion statements (see Table 6.2 below) which are used as a guide in judging a candidate’s response for each attribute.

<table>
<thead>
<tr>
<th>Attribute (advanced surgical training)</th>
<th>Criterion statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ability to interact effectively and affably with peers, mentors, members of the health care team, patients and their families.</td>
<td>A suitable candidate will be aware of the need to communicate at the level, and in a manner appropriate to the setting and circumstances of the interaction, and in particular recognises the need for affability and avoidance of arrogance, judgemental or patronising behaviour.</td>
</tr>
<tr>
<td>The ability to contribute effectively to as a member of a health team.</td>
<td>A suitable candidate will demonstrate the potential to work well in a team by describing a positive attitude to collaboration which recognises the roles and needs of other team members, shows appropriate leadership skills and acknowledges the effect of his/her own attitude and behaviour on team morale and effectiveness.</td>
</tr>
<tr>
<td>The ability to act ethically, responsibly and with honesty.</td>
<td>A suitable candidate will be sensitive to, and recognise the ethical dimensions of day to day professional activities, be aware of and apply appropriate ethical and moral principles and act responsibly and with honesty when making professional decisions.</td>
</tr>
<tr>
<td>The ability to perform realistic self-assessment</td>
<td>A suitable candidate will show insight into his/her own performance (decision...</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Attribute (advanced surgical training)</th>
<th>Criterion statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>assessment.</td>
<td>making as well as technical skills) by demonstrating a willingness to systematically seek out, and be receptive to, evaluative feedback from all appropriate sources, while recognising and acknowledging the limits of his/her own knowledge and skills by acting appropriately to improve them.</td>
</tr>
<tr>
<td>A capacity for caring, concern and sensitivity to the needs of others.</td>
<td>A suitable candidate will demonstrate a capacity for empathy by acknowledging and showing concern and understanding for the thoughts and feelings of others, and by providing emotional support and practical advice to encourage autonomy and self-respect.</td>
</tr>
<tr>
<td>Effective spoken communication</td>
<td>A suitable candidate will demonstrate in the interview setting basic listening and speaking skills commensurate with the need to communicate succinctly, fluently and effectively in clinical and professional settings.</td>
</tr>
</tbody>
</table>
Case study – selection of trainees for advanced orthopaedic surgical training program 2002 by Australian Orthopaedic Association

The purpose of the case study is to provide an example of how the selection process for advanced surgical trainees operates in practice. The case study details the selection process for entry into the advanced orthopaedic training in Queensland in 2002.

Selection into the 2002 Queensland advanced orthopaedic training program was based on an assessment of:

1. an applicant’s curriculum vitae;
2. referee reports;
3. discussions with people for whom an applicant was working in relation to surgical skills, knowledge, ability to present cases, decision making ability, patient communication, patient management, teaching skills, interaction with other medical staff, reliability, diligence, honesty, insight and ability to follow instructions; and
4. performance at structured interviews of 10 minutes each covering ethics and principles, undergraduate and post graduate training, clinical situations and practical skills.

The Commission notes that this process appears to be different to the process described in the College’s application. In particular, it includes discussions with people for whom the applicant is working. The interview component also appears to be structured differently.

Curriculum vitae and referee reports

Assessment was carried out by a training committee consisting of 13 members. For the 2002 training program, 14 applications for advanced orthopaedic training program in Queensland were received. Applications were ranked in order by each training committee member. The rankings were averaged and a score then assigned to each application. For the 2002 training year, the applicants receiving the top seven scores were accepted into advanced training in Queensland.

With regard to referee reports, three questions were asked of referees. The first question requested a level of recommendation and grades the answers 1-5. The second question asks for the referees to state their preparedness to work with the applicant, with there being 4 levels of reply possible. The third question requires an overall rating of the applicant’s clinical qualities with 4 grades of reply possible. The top seven successful applicants for the 2002 training program achieved between 1 and 2.5 demerit points in this section.

Interview

The interview session is comprised of 4 different interviews with a different interviewer at each station. The interviews explore ethics and principles, training and research, clinical situations and practical skills. The scoring system used was:

Very poor

This case study was sourced from a letter from the Queensland Branch Training Committee of the Australian Orthopaedic Association provided to the Commission during the course of considering the application for authorisation.
Based on the applicant’s curriculum vitae, referees reports and interview performance, each applicant was ranked and the top seven candidates accepted into advanced orthopaedic surgical training. Verbal feedback is also provided on applicant’s work performance; however, these comments are not crucial in the assessment.

Training advanced surgical trainees

6.49 Advanced surgical training extends over four or more years, depending on the sub-speciality concerned, and involves the application of surgical sciences appropriate to the sub-speciality as well as to the practice of surgery. As with basic surgical training, advanced training programs generally operate in a similar manner to an apprenticeship system. Advanced trainees’ work in accredited training positions under the supervision of College Fellows, and acquire exposure to and experience in a range of diagnostic and treatment procedures as outlined in the relevant syllabus. The Commission is advised that each Fellow would supervise on average one to two trainees at a particular institution. Each trainee could be under the supervision and teaching of between three to six consultants, and would average seven sessions per week of contact with their consultant. The trainee also accepts escalating responsibility in operative surgery and undertakes more complex operative procedures as the program progresses.

6.50 Training is hospital based. During advanced training, a trainee occupies a structured cycle of College accredited hospital posts of six months’ duration. The Commission understands that advanced trainees generally rotate through a series of different hospitals during training, at least one of these being a non-metropolitan post. The trainee’s hospital rotations are closely monitored by supervisors to ensure that sufficient and competent experience is obtained in specified surgical procedures.

6.51 Trainees are provided with a Guide to Surgical Training which contains the syllabus for their chosen surgical specialty. The Commission understands that the level of detail of the syllabus varies with each specialty. For example, the Board of Neurosurgery provides a syllabus to trainees which, amongst other things, lists the core tutorial topics and provides an extensive recommended reading list. Some specify the main academic areas on which trainees need to focus in conjunction with the ‘hands on’ training program provided in the hospital environment, as well as the area and number of surgical procedures that need to be undertaken by the advanced trainee. However, this is a guide only. The Commission understands that other specialties provide trainees with a more detailed syllabus.

6.52 The Commission understands that advanced trainees are also required to attend a range of after hours educational activities. These vary between hospitals and from State to State, but would generally include the following activities:

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96 College submission to the Australian Medical Council for Accreditation, May 2001, p21.
specific topic meetings where each trainee would prepare a presentation on a certain topic presenting this to the assembled group and be prepared to answer questions and participate in further discussion;

• case presentations;

• presentation of selected journal articles to keep up to date with the current literature in an open forum and to specifically explore the trainee’s knowledge and effort to read around these topics;

• trial examination sessions, particularly for later year trainees to improve their exam technique and test and improve their knowledge base;

• teaching ward rounds; and

• consultant presentations where specific topics are presented in a mini lecture format to facilitate discussion. The College advises that in order to deal fairly and appropriately with each trainee and with each topic, full participation cannot be open to everybody. People interested in surgical training may attend these sessions as part of an educative experience, but the timeframe would not allow them to participate as a full member of the group, without detriment to the time allocated to trainees occupying accredited posts.

In addition, advanced surgical trainees are required to complete an investigative project which may be in the form of a presentation of a paper, a publication in a journal, a dissertation with a written review of a clinical problem, a period of full time research, or a higher degree. The project is certified by the Regional Sub-Committee to the relevant Specialty Board prior to the trainee sitting the Part 2 (Fellowship) Examination.

Advanced trainees may also undertake part-time or interrupted training after a full year of the advanced training program has been completed in a full-time capacity.

Advanced surgical training is overseen by the Censor-in-Chief, who chairs the Board of Advanced Surgical Training. Each of the Speciality Surgical Boards are represented on this Board. For some surgical specialties, the College has delegated responsibility for training activities to various speciality associations.

The training requirements for each of the College’s surgical areas are briefly outlined below.

**General surgery**

The General Surgical Board of the College oversees the general surgery program. The period of training is five or six years. The first three years cover a broad range of surgical procedures, while the remaining two or three years focus on one sub-specialty area. Training in general surgery overlaps with the other specialities.

**Cardiothoracic surgery**

The Cardiothoracic Surgical Board of the College oversees this program. Cardiothoracic trainees must spend two years in advanced training in general surgery and four years in advanced training in cardiothoracic surgery. For trainees who already hold a fellowship in general surgery, the advanced training program in cardiothoracic surgery will comprise three years in approved cardiothoracic surgical posts performing open-heart surgery for acquired and congenital heart disease.
Neurosurgery

6.59 The Neurosurgery Board of the College and the Neurosurgical Society of Australia oversee the advanced training program for Neurosurgery. Neurosurgery training extends over a five-year period. The training program incorporates the management of head injuries and other injuries of the nervous system.

Orthopaedic surgery

6.60 The Orthopaedic Board of the College and the Australian Orthopaedic Association oversees this program. Training in orthopaedic surgery is conducted over a minimum of four years, with the option of spending one of those years in an approved medical, general surgical or research post. Trainees are required to sit for an orthopaedic principles and basic sciences exam during their first year, which is unique to this specialty.

Otolaryngology - head and neck surgery

6.61 The Otolaryngology – Head and Neck Surgery training program is overseen by the Board of Otolaryngology – Head and Neck Surgery of the College and the Australian Society of Otolaryngology – Head and Neck Surgery. Training is conducted over a five year period, and trainees are expected to become familiar with all aspects of medicine and surgery involving the main subdivisions of the sub-speciality, namely otology, rhinology, larynology and head and neck surgery.

Paediatric surgery

6.62 The Paediatric Board of the College and the Australasian Association of Paediatric Surgeons oversees the advanced surgical training program. Training extends for six years, consisting of three years in the general surgical training program and a further three years in an approved paediatric surgical training program including the completion of the advanced paediatric life support course. Alternatively it consists of five years of general surgery in the approved hospital training program to obtain a Fellowship in General Surgery followed by three years in clinical training in approved paediatric surgical positions.

Plastic and reconstructive surgery

6.63 The Plastic and Reconstructive Surgery Specialty Board of the College oversee this program. Plastic and reconstructive surgery requires five years of training consisting of one year in the general surgical training program and a further four years in the plastic and reconstructive surgical training program.

Urological surgery

6.64 The Board of Urology of the College and the Urological Society of Australasia oversees the advanced training program, which consists of one year in the general surgical training program and a further four years in the urological surgery training program.

Vascular surgery

6.65 The Vascular Surgical Board of the College oversees this program. Vascular surgery requires five years of training involving two years in the general surgical training program and three years in the vascular surgery training program.
Assessment of advanced surgical trainees

6.66 Assessment of advanced surgical trainees consists of three primary elements, namely:

- the maintenance of log books by the trainee;
- the completion of in-training assessment reports by the surgical supervisor; and
- the Part 2 Examination.

Logbooks

6.67 Logbooks are the medium through which the Specialty Boards (or affiliated surgical associations where relevant) review the progress of trainees, and particularly the minimum number of procedures that need to be completed by each advanced trainee. In this regard, all specialties require trainees to complete a logbook setting out the number and range of operations they have completed. More specifically, logbooks also provide information on:

- operation statistics and outcome of surgery; and
- educational activities, such as research, publications, presentations at meetings and attendance at courses.

6.68 The logbooks are reviewed every six months by training supervisors. They are also used by accreditation inspection teams to assess the worth of the individual training post.

In-training assessment reports

6.69 Surgical supervisors are required to complete an in-training assessment report on advanced trainees at the conclusion of each six month term. Reports are read and signed by the trainee. An interview with the trainee is also required and a mid-term review of performance is recommended. This assessment relates to the trainee’s overall performance and takes into account various factors including:

- attitude;
- clinical skills;
- technical skills;
- teaching/continuing medical education;
- research; and
- logbook statistics.

6.70 If a trainee’s performance is deemed unsatisfactory, the term in question will not be credited towards the trainee’s program. Deficiencies in performance are identified by their supervisor and discussed with the trainee, and strategies for improvement are suggested. Continuing poor performance may result in dismissal from the program. Greater detail in relation to procedures for dismissal from the Advanced Surgical Training program is provided below.

Part 2 (Fellowship) Examination

6.71 Trainees have to apply to the Censor-in-Chief for permission to sit for the Part 2 Examination. The examination is normally undertaken in the final year of advanced training. In making this decision, the Censor-in-Chief may take into account:

- recommendations of the relevant Specialty Board concerning satisfactory length and scope of training;
confidential reports from supervisors of training; 
referee reports; and 
information from logbooks.

6.72 Each surgical sub-specialty has a different examination, covering the requirements laid down in each syllabus. Generally, the examination has six segments:

- Written Papers I and II;
- a clinical examination of a ‘long’ case. This exercise is approximately 40 minutes in duration and is conducted in a clinical setting with a high level of complexity;
- a half hour oral examination on operative surgery;
- a half hour oral examination on surgical pathology; and 
- a half hour oral examination on surgical anatomy, with specimens.

6.73 Advanced trainees may re-sit the examination should they be unsuccessful, and there is no formal limit on the number of times a trainee may sit the Part 2 Examination. However, the Censor-in-Chief must approve eligibility to sit the exam each time. The pass rate for the Part 2 Fellowship Examination from 1995 to 2000 is detailed in paragraph 6.155 and Table 6.5 below.

Dismissal from the advanced surgical training program

6.74 An advanced surgical trainee may be dismissed from the program for repeated unsatisfactory performance as identified in the in-training assessment reports.

6.75 At any time during training, a trainee may receive a written warning which details specific deficiencies in his or her performance and specifies the goals to be achieved in remedying the deficiencies in a suitable time frame. A trainee may also be informed that they are underperforming at the time of his or her six-monthly assessment report.

6.76 Generally, a trainee is given a minimum of two written warnings before dismissal is considered. However, in the event of serious misconduct, dismissal may occur at any time. In the event that a trainee receives two written warnings, the Hospital Supervisor for Surgical Training (responsible for coordinating the basic surgical training program, for advising trainees and ensuring the completion of their in-training assessment reports) provides a written report to the Regional Sub-Committee of the relevant Specialty Board. The trainee is provided with two weeks’ notice of a meeting with the Regional Sub-Committee, where the trainee is invited to prepare a submission in relation to the documented deficiencies. A record of the meeting is kept, including the Committee’s recommendation about whether to dismiss the trainee from the advanced training program. The onus is on the Regional Sub-Committee to substantiate its decision to the Specialty Board, which makes its decision based on the recommendation of the Committee. Before the decision is ratified, the Censor in Chief must be satisfied that due process has been followed and be provided with documentary evidence of warnings and minutes of any meetings discussing a trainee’s performance.97

97 College submission to the Australian Medical Council for Accreditation, May 2001, (Attachment 37), Guidelines for Surgical Boards in Dismissing Advanced Surgical Trainees from the Training Program.
**Training costs**\(^98\)

**Basic surgical training**

6.77 In 2003, the total course cost of the basic surgical training program in year 1 is $7850 and $8150 in year 2. These figures consists of:

- registration fee (year 1) of $1225;
- annual training fee of $2100;
- distance learning program (year 1) $1775;
- basic surgical skills course (year 1) $1375;
- Early Management of Severe Trauma course (year 1) $1375;
- Care of the Critically Ill Surgical Patients course (year 2) $1375;
- Multiple Choice Examination (year 2) $3400; and
- Objective Structured Clinical Exam (year 2) $1275.

**Advanced surgical training**

6.78 The total course cost of the advanced surgical program varies depending on the surgical sub-speciality and the length of training. Common costs include:

- registration fee (year 1) of $1225;
- annual training fee $2100; and
- Part 2 Examination entry fees of $4500.

6.79 The 2003 annual subscription fee to the College (payable on 1 January 2002) was $1600. The Fellowship entrance fee is $5000 (payable in full for a 10% discount or over five years).

**Granting of College Fellowship**

6.80 For advanced surgical trainees who pass the Part 2 Examination and who have completed training, a recommendation for admission as Fellow is made to the Council of the College by the Censor-in-Chief, on the advice of the relevant Surgical Board. If Council approves the recommendation, the Diploma of Fellowship (FRACS) is awarded.

6.81 The College retains the discretion to withhold granting of Fellowship to trainees who have successfully completed advanced surgical training, although it submits this discretion has never been exercised.\(^99\)

**Accreditation of hospitals and hospital training posts**

6.82 The aim of the College’s accreditation process is to ensure trainees receive the quality of training necessary to produce safe and competent surgeons. With respect to basic surgical training, the College accredits the hospital itself. However, for advanced surgical training, each advanced surgical post within the hospital must be accredited.

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\(^98\) Figures sourced from the College website at [www.racs.edu.au/news\(,\) Summary Of Subscriptions For 2003 And Examination, Training and Other Fees for 2002 & 2003.]

\(^99\) College submission to the Commission, May 2001.
Accrediting hospitals to provide basic surgical training

Accreditation criteria

6.83 The accreditation criteria that must be met by hospitals wishing to provide basic surgical training are:

- that the hospital has a Basic Surgical Training Supervisor appointed by the Board of Basic Surgical Training;
- that the Basic Surgical Supervisor is provided with adequate support (secretarial, office);
- that there is a library;
- that there are internet facilities enabling access by basic surgical trainees to the College’s basic training website;
- that the hospital has appropriate processes for clinical audit and for review of morbidity and mortality;
- that there is a simple facility for all basic surgical trainees to practise basic surgical skills (a room, cupboard, desktop with basic equipment);
- that there is commitment from surgeons of the hospital to support the basic surgical training skills courses and the basic training examinations;
- that basic surgical trainees are involved in using and developing basic surgical skills and their progress is monitored;
- that there are opportunities for basic surgical trainees to be involved in acute patient resuscitation;
- that surgeons are involved in mentoring basic surgical trainees;
- that basic surgical trainee rotations undergo review with input from trainees;
- that clinical rosters are appropriate; and
- that study leave is provided for designated College basic surgical courses.

Accreditation process

6.84 The College requires a hospital to provide it with extensive documentation, followed by an inspection of the hospital by representatives of the College.

6.85 Surgeons are appointed for one calendar year at a time to perform hospital site visits for a particular region. Surgeons may be re-appointed on an annual basis. Inspections are completed and reported to the relevant Regional Sub-Committee of the Board of Basic Surgical Training.

6.86 A hospital inspection occurs on a day arranged with the hospital. In assessing the hospital against the above listed criteria, the basic surgical training inspectors interview the:

- Basic Surgical Training Supervisor;
- trainees at the hospital;
- Director of Medical Services; and
- Director of Clinical Training.

6.87 Based upon the joint recommendations of the Director of Medical Services and the Director of Clinical Training regarding the possible number of basic surgical training posts at the hospital, the inspectors make a recommendation to the Regional Sub-Committee regarding the maximum number of posts available for basic surgical trainees at each hospital. This recommendation takes into account whether
basic surgical trainees in the first year of the program will be able to move into subsequent basic surgical posts within the same hospital in the second year of the program.

6.88 In addition, the inspectors make an assessment regarding the possible number of training posts available for trainees in years three or four of the basic surgical program. Inspectors may interview supervisors of advanced surgical training to assess these numbers. Trainees occupying such posts include trainees who have not sat the Part 1 multiple choice exam, who have sat but not yet passed the multiple choice exam, or who have passed the entire Part 1 basic training examination but have not yet been accepted into advanced surgical training. Trainees in these positions are expected to have registrar level responsibilities. They will include posts formerly referred to as ‘non-accredited’ registrar positions. Registered basic surgical trainees occupying such posts are now referred to as ‘basic surgical training registrars’, which reflects both their employment designation and their College training designation.

6.89 The number of hospitals accredited for basic surgical training during 2001 is discussed below at paragraphs 6.156 – 6.162.

6.90 Rural hospitals involved with trainee rotations are assessed separately for their suitability for basic surgical training according to the above listed criteria.

6.91 The following reports are provided by hospital inspectors to the Regional Basic Surgical Training Committee and the Board of Basic Surgical Training:

- a report on the extent to which each hospital in the region meets the assessment criteria;

- a general report on basic surgical training in the region which has been assessed, with an assessment of the number of posts from year one to four of basic surgical training which can be supported within the region. Particular clarity is required with respect to year one and year two of basic surgical training. The report should also include an indication of the reasonable number of positions available for entry into year one of basic surgical training and the probable maximum number which could be reached if expansion of these numbers were required in the future; and

- a more general report reflecting the implementation of basic surgical training measured against the available basic surgical training regulations and guidelines. The report should include aspects of the functioning of the basic surgical training program in the region which should be addressed by the Regional Basic Surgical Training Committee. The report may also include reference to aspects of the basic surgical training curriculum objectives which should be referred to the Board of Basic Surgical Training for consideration.

Accrediting advanced surgical training posts

Accreditation criteria

6.92 Training posts are accredited according to criteria specified by the Board of Surgical Training responsible for the post. However, there are some common criteria each advanced surgical training post must satisfy, namely:
provision of clinical experience to ensure the development of diagnostic,
therapeutic and operative skills:
- in the operative room
- in peri-operative care;
- in the emergency room, including trauma; and
- in the ambulatory or outpatient setting;

access to teaching and educational workplace programs to ensure acquisition of
knowledge and the development of a life long education strategy:
- regular clinical and educational meetings within the hospital or related
  institutions, relevant to the stage of surgical training;
- availability of educational resources including a medical library and
  information technology;
- support and encouragement for self-directed learning;
- opportunities for critical appraisal of the medical literature; and
- opportunities for teaching students and junior staff; and

access to peer review and surgical audit to promote accountability, safety, quality
assurance, error recognition and correction and clinical standards setting,
including but not restricted to:
- regular peer review meetings; and
- maintenance and review of clinical experience.

The Commission understands that in addition to the above criteria, each surgical
specialty requires specific services or facilities appropriate to that specialty. For
example, the ideal requirements for a plastic surgery unit include:

- there should be an adequate number of consultants all of whom should be
  involved in post graduate activities;
- there should be a minimum of 14 beds, and a suitable examination and dressing
  room adjacent to the ward;
- operating facilities should form part of a major operating suite;
- the clinic should have access to other clinics such as audiology, dermatology,
  orthopaedics, dental and orthodontics;
- medical records and secretarial help is essential;
- the unit should engage in a substantial range of plastic surgery work from among
  the following categories: paediatric, facial, head and neck, burns, general (skin
  cancer, lymphoedema) and aesthetic;
- regular journal meetings with supervisors and trial exams may be of value to an
  advanced surgical trainee;
- there should be adequate time for research and presentation of papers;
- units should have access to a computer for data storage and analysis of
  information in plastic surgery;
- the unit should have access to comprehensive photographic and art facilities;
- a nurse training program in plastic surgery is a desirable addition to a unit;
- access to a prosthetics laboratory is valuable; and
- all approved units must be inspected every five years.

In addition to meeting specific surgical training criteria, to obtain accreditation each
individual hospital should also provide the following:

- a range of surgical supervisors;
appropriate case load and case mix;
- a balanced hospital service, preferably with recognition by the Royal Australasian College of Physicians for training in internal medicine;
- anaesthetic staff with approved higher qualifications recognised by the Australian and New Zealand College of Anaesthetists;
- intensive care staff with approved qualifications from the Joint Faculty of Intensive Care;
- a laboratory service including adequate clinical pathology morbid anatomy, microbiology and biochemistry;
- access to an appropriate number of autopsies;
- access to appropriate information technology equipment;
- recognition of the AMA Safe Hours policy;
- an adequate diagnostic radiology department;
- an emergency accident service with 24 hours resident medical officer cover;
- outpatient clinics providing a comprehensive consultative service (although full accreditation may still be granted without an outpatient clinic);
- an effective system of hospital records;
- an adequate establishment of resident medical officers;
- a surgical education committee or its equivalent;
- appropriate variety of clinical material for training;
- adequate personal operative experience for the trainee under the supervision of surgeons possessing higher surgical qualifications recognised by the College;
- each training period must provide a reasonable period of continuity (normally at least six months for Advanced Surgical Training);
- structured teaching program for Advanced Surgical Trainees;
- additional training facilities should include a medical reference library, regular formal clinical meetings and conferences and the opportunity to attend surgical education meetings; and
- a surgical audit system.

The accreditation process

6.95 There are two stages of the accreditation process. First, the College requires a hospital to provide it with extensive documentation, including information on hospital facilities, case numbers and educational opportunities for all trainees, which is then followed by an inspection of the hospital by representatives of the College.

6.96 In relation to all advanced surgical posts, the College adopts the following accreditation procedures:

- On advice of the relevant Surgical Board, the Censor in Chief (who Chairs of the Board of Advanced Surgical Training, and reports to the Education Policy Board) will appoint an inspection team, which comprises a minimum of two representatives of the Surgical Board who are not involved with the applicant hospital. The Commission understands it is possible to appoint interstate or New Zealand surgeons to this team if necessary.

- The College will liaise with the hospital administration, the Hospital Supervisor of Surgical Training, the Speciality Supervisor and the inspection team to arrange a suitable time for the inspection.

- The inspection team interviews the Hospital Supervisor of Surgical Training,
the Speciality Supervisor and each advanced surgical trainee in the program when conducting a review of an existing accredited post. The inspection team will then inspect the unit and related facilities. The team normally reviews the logbook of each advanced trainee in each program. At the conclusion of the visit, the team holds a discussion with the Supervisors and the administrative staff to obtain further information prior to compiling the inspection report.

- The inspection team presents the final report to the hospital for a response prior to final deliberations of Council on the report.

6.97 In addition, the Commission understands that inspection reports note whether funding (for example salaries) is secured for the post and may comment on the teaching skills of the surgeons on staff. They also record certain hospital statistics including the number of surgical beds and population served, and statistics of the relevant surgical unit including annual separations, weekly operating sessions, whether there are dedicated ward and nursing staff.

6.98 Furthermore, the Commission understands that accreditation reports provide scope for inspectors to record the strengths and weaknesses identified in relation to a particular advanced surgical post. For example, a trainee’s exposure to research activities and certain surgical procedures to ensure there is enough clinical material may be noted.

6.99 However, the report may list specific issues, which if rectified at the time of review, would ensure accredited status. Limited accreditation of hospital training posts is discussed in further detail below.

Monitoring and review of accredited posts

6.100 Each of the surgical sub-specialities of the College annually monitors whether training posts and hospitals continue to meet accreditation requirements. The Commission understands that this is done primarily through the trainee logbooks, which provide information on the number and type of operations that the trainee has undertaken and the level of supervision of the trainee.\(^\text{100}\)

6.101 Accreditation is reviewed by College Fellows at the request of hospitals or according to the College’s rolling schedule of hospital inspections. The process followed by the College in reviewing an accredited post is essentially the same as that previously described above at paragraphs 6.95 – 6.98.

6.102 In carrying out this monitoring role, the College may disaccredit a hospital training post on the basis of their being a material change in circumstances where required standards are no longer being met.

Duration of accreditation

6.103 The duration of a hospital post accreditation is normally five years for a principal teaching hospital, where the bulk of training programs are located, and one year for an affiliated hospital.

6.104 However, it appears possible to accredit posts for a more limited period. In particular, if hospitals or posts do not meet all criteria, yet are able to satisfy the main

\(^{100}\) College submission to the Australian Medical Council for Accreditation, May 2001, p17.
components and are granted limited accreditation, usually for a period of one year, subject to rectifying the outstanding criteria in three, six or twelve months time. Limited accreditation is granted only where the outstanding criteria are relatively minor and would not have a detrimental impact on the overall training program.

6.105 Further detail regarding the number of hospital posts accredited for advanced surgical training, is provided at paragraphs 6.157-6.162.

Assessment of overseas trained practitioners

6.106 Applications from overseas-trained practitioners for specialist recognition in Australia are referred to the College mainly from the AMC. In 2000, the College received 80 applications for assessment from overseas-trained practitioners. The College also receives a very small number of applications directly from overseas-trained practitioners where the applicant has an AMC Certificate.

6.107 The purpose of this assessment procedure, as developed by the AMC and the College, is to assess the equivalence of training and qualifications and experience of overseas-trained practitioners with Australian-trained practitioners.

Assessment criteria

6.108 The application process and guidelines used by the College for assessment are the same for all applicants regardless of the proposed position the applicant wishes to hold. The role of the College is to assess the qualifications, training and experience of an overseas-trained surgeon to determine what further requirements, if any, must be met to be assessed as equivalent to an Australian-trained surgeon in the relevant surgical specialty. For example, an overseas-trained practitioner with 20 years’ experience will be compared against an Australian-trained practitioner with the same amount of experience. The Commission understands that the practitioner’s experience is primarily assessed via an examination of his or her logbooks.

6.109 For an overseas-trained surgeon whose specialisation is narrower than the surgical specialties in Australia the College advised the Commission that it would assess the equivalence of the overseas-trained surgeon against an Australian-trained surgeon with a similar number of years experience in the same narrow field of surgery. The College recommendation would identify that the surgeon had been assessed as equivalent to an Australian-trained surgeon in the narrow field only.

Assessment process

6.110 The College receives applications from the AMC on behalf of overseas-trained surgeons throughout the calendar year. The College generally follows the assessment procedures specified in the AMC/Committee of Presidents of Medical College’s Assessment of Overseas Trained Specialists Template for Colleges. Briefly, international applicants are required to supply the College with specific documentation in relation to their training and qualifications. The College does not

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101 Royal Australasian College of Surgeons supporting submission to the application for authorisation, 30 March 2001.
102 Oral submission from the College, 3 April 2002.
begin assessment of an application until an applicant supplies all the necessary information.

6.111 The application is then forwarded to an assessment team at the College comprising the relevant Specialty Board Chairman and the Censor-in-Chief, and/or the Executive Director of Surgical Affairs. Following documentary evaluation, an interview with the applicant is normally scheduled to clarify the applicant’s experience. The interview panel comprises the relevant Specialty Board Chairman, the Censor-in-Chief and/or his/her nominees. Nominees may include other Board Chairmen or the College’s Executive Director of Surgical Affairs.¹⁰³ The College determines what further requirements an applicant must meet, if any, and makes a recommendation in writing to the relevant referring agency.

6.112 A general overview of the assessment procedure for overseas-trained practitioners in Australia, including the role of the AMC and the relevant medical college is provided in Figure 6.1 below.

**Figure 6.1: Overview of the assessment process for overseas-trained practitioners**\(^{104}\)

1. Initial inquiry from overseas trained practitioner
2. Applicant receives AMC information leaflet and preliminary application form
3. Preliminary application form returned to AMC with fee
4. Applicant sent information booklet with details of assessment procedures, required supporting documents and application form
5. Applicant returns completed forms and accompanying documents to AMC
6. Initial assessment by AMC to establish bona fide qualification, occupational English test result (or exemption) and completed supporting documents (4-6 weeks)
   - If uncertain about documents: Refer to relevant college for advice
   - If documents in order:
     - (i) Referred to relevant college for assessment
     - (ii) Applicant advised and submits application form and fee to the college
   - If documents not complete:

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\(^{104}\) Australian Medical Council *AMC/Specialist Medical College Assessment Procedures Information 2001*, pp17-18.
Figure 6.1 continued

ASSESSMENT PROCEDURES OF RELEVANT MEDICAL COLLEGE

ASSESSMENT OF DOCUMENTATION

Approve qualifications

Further training

Formal examination (and)

If successful:
Relevant college advises AMC
Relevant college may award Fellowship

AMC formally advises applicant

Applicant eligible to apply to State/Territory Medical Boards for registration

If unsuccessful:
Relevant college advises AMC

AMC notifies applicant of outcome

Applicant may apply to sit the AMC examination

Assessment of documents

Not recognised medical speciality
Documentary evidence

6.113 As previously mentioned, applicants are required to provide a range of documentation for assessment by the College, namely:

- a comprehensive curriculum vitae;
- full details of the applicant’s training, including the basic sciences component, and the applicant’s clinical surgical experience;
- details of each surgical post held by the applicant including in-training supervision and details of the supervising surgeons; the nature of the service provided; specific responsibilities and experience gained; evidence of in-training evaluations; and a copy of logbook statistics including a certified summary of those statistics;
- certified copies of undergraduate medical degree and any post graduate qualifications;
- an outline of any examinations undertaken including their nature. This involves providing details of the syllabus and results, including certificates;
- details of specialist practice including the location, nature and duration of specialist practice. Applicants must also provide the College with a letter from the privileges/credentialing committee of the hospital in which they practised and an audit for at least, their most recent year of specialist practice; and
- the names and current contact details of three referees. Nominated referees must include a senior colleague who has worked with the applicant within the last two years, a colleague who is located geographically in the same area as the applicant, and a colleague who practices in the applicant’s specialty area.

6.114 The Commission understands that the College is not bound by any time limit in carrying out its assessment process.

Interview

6.115 Following documentary evaluation by the assessment team, an interview is normally scheduled. Further detail regarding the composition of an interview panel is contained above at paragraph 6.111.

6.116 The purpose of the interview is to clarify any aspects of the applicant’s surgical practice and training that are not immediately evident in their documentation. In addition, the following attributes are assessed during the interview:

- the ability to act ethically, responsibly and with honesty;
- the ability to perform realistic self assessment;
- the ability to contribute effectively as a member of a health care team; and
- effective spoken and written communication.

6.117 The overseas-trained doctor’s knowledge of the Australasian health care system is also assessed during the interview. The Commission understands the interview runs for approximately 50 minutes, and is conducted in accordance with an interview pro-forma developed by the College. It consists of a mixture of standard questions and hypothetical scenario questions.

6.118 The overseas-trained practitioner’s responses are rated against a criterion statement linked to each of the above listed attributes. The ratings range from an excellent response to a non-suitable response (1-5). The criterion statements are similar to those listed previously at Table 6.2.
6.119 Further detail regarding the assessment of overseas-trained practitioners, including the length of time taken to review an overseas-trained practitioner’s qualifications and the countries where applicants completed the most recent training, is provided in paragraphs 6.165 – 6.167.

Recommendation

6.120 The recommendations arising from the interviews are determined by the profile of the individual applicants. The assessment team may recommend to the relevant referring agency that overseas applicants undertake further training and/or assessment before obtaining registration. In particular, applicants may be recommended to:

- successfully complete basic surgical training, including the Part 1 exam;
- successfully complete specific components of basic surgical training;
- if exempted from basic surgical training:
  - apply in open competition to successfully complete the entire advanced training program, including the Part 2 Examination, in the chosen specialty;
  - apply in open competition to enter the advanced training program in the chosen specialty with the possibility of review following a specified minimum time. Following review, the applicant may be required to undertake further training or be granted permission to apply for and sit the Part 2 Examination in that specialty;
  - undertake a specified period of on-site assessment of professional practice and, upon successful completion of all requirements during this assessment, successfully complete the Part 2 Examination; or
  - undertake a specific period of on-site assessment of professional practice and upon successful completion of all requirements during this assessment, apply for admission to Fellowship by election under the Articles of Association of the College (Article 21).

6.121 The aim of the period of on-site assessment is to allow surgeons to demonstrate and consolidate their clinical knowledge, skills and professional practice and to experience a period of acclimatisation to the local health care system under surgical supervision. If the surgeon is working in an Area of Need position (discussed below), oversight by a surgical supervisor may be provided at a distance.

6.122 During a period of on-site assessment, the College requires two nominated College Fellows to prepare progress reports on the overseas-trained practitioner. The overseas-trained surgeon is also expected to register in the College’s ‘Maintenance of Professional Standards’ program requiring participation in continual medical education, surgical audit and peer review. Retrospective recognition of a period of assessment may be considered, provided that the requirements of audit, education and reporting are met.

6.123 Generally, an overseas-trained doctor will be recommended to sit the Part II Examination if they have recently been certified by the Board of the Accreditation Council for Graduate Medical Schools in the United States of America or have recently been issued a Certificate of Completion of Specialist Training in the United Kingdom. Overseas-trained doctors with years of surgical experience would generally be recommended for a period of assessment followed by an invitation to...
apply for election to Fellowship under Article 21 of the College’s Memorandum and Articles of Association.

Regulations for granting exemption from the Part 1 Assessment

6.124 Exemption from basic surgical training will be granted where the overseas-trained applicant holds particular qualifications. These qualifications currently are:

- the Applied Surgical Sciences and Principles of Surgery Package of the United Kingdom and Irish surgical colleges;
- the full Fellowship of the College of Medicine of South Africa; and
- holders of the MRCS/AFRCS Examination in the New British Surgical Training Schemes would normally be granted exemption from the Part 1 Examination. Individual Boards may specify further training and mentor assessments prior to the candidates being accepted for Advanced Surgical Training. \(^{106}\)

Area of need assessment

6.125 The College also assesses the training, qualifications and experience of an overseas-trained practitioner for positions declared as an ‘Area of Need’ (AON) by state and territory health authorities. As discussed in Chapter 2, An AON refers to positions which are unable to be filled by local medical practitioners (see paragraph 2.27).

6.126 As of 1 June 2002, a new process to streamline the assessment and registration of overseas-trained specialists for AON positions was introduced. The new process was developed by the AMC and Committee of Presidents of Medical Colleges following a National Forum on AON practitioners held in Sydney on 1 December 2000. The Commission’s understanding of the College’s assessment procedures under the new system are outlined below.

6.127 Applications from overseas-trained practitioners for AON assessment are referred to the College from health service providers (for example the employing hospital). Before an AON application is referred to the College, a hospital identifies that a surgical position is required to be filled.

6.128 The Commission understands that whilst the employer has ultimate responsibility for the AON position description, the employer should liaise with the relevant Specialty Board of the College in developing key selection criteria to ensure that the skills and expertise required are appropriate to the field of specialist practice and the position to be filled. The position description should include such information as: \(^{107}\)

- the position title;
- a comprehensive statement of duties;
- qualifications and experience – identifying and distinguishing between what selection criteria are regarded as ‘essential’ or ‘desirable’ and clarifying


whether applicants must demonstrate either that they have practical experience 
or show that they have aptitude in a particular aspect of clinical practice;

- special requirements of the position which may be due to the geographic 
  location or the specific nature of the medical services to be provided;
- clinical practice privileges or appointments relating to the position;
- any special conditions of employment; and
- the remuneration package of the position, including whether the applicant will 
  be providing services that need to attract the Medicare rebates.

6.129 Once AON position description has been prepared, the hospital contacts the relevant 
State or Territory health authority to have the position declared as an AON position.  
If the position is approved, the hospital selects one suitable applicant who meets the 
position description and selection criteria.  It is at this stage that the hospital refers the 
single application to the College, in the case of a surgical AON position, for 
assessment.

6.130 The College advised the Commission that the assessment process for area of need 
positions is the same as that carried out for all other overseas-trained practitioners.  
However, the College focuses on assessing the competency of the applicant to 
perform specific procedures outlined within the area of need position description.

**Documentary assessment**

6.131 Initially, the College receives a range of documentation from the employer’s single 
preferred candidate in order to assess the suitability of the candidate for the AON 
position.  At the same time, the employer refers the single application to the AMC to 
verify documentation.

6.132 To be a suitable candidate for the position, the College must consider that the 
applicant is ‘close’ to being comparable to an Australasian-trained surgeon in the 
same specialty area; requiring no more than two years in a designated period of 
assessment.  If the candidate is deemed to require additional training as a means of 
attaining comparability to an Australasian-trained surgeon in the same specialty, they 
will not be recommended as a suitable candidate for the position.108

**Interview**

6.133 If the College remains undecided as to any aspect of the candidate’s training, 
qualifications and/or experience, an interview is held with the relevant Speciality 
Board Chairman and the College Censor-in-Chief and/or his nominee(s).

6.134 Under the new process for AON assessment, within 8 weeks of receiving satisfactory 
documentation, the College is required to make its recommendation to the relevant 
state or territory medical board regarding the appropriate category of AON 
registration.  At the same time, the College will define any limitations on the nature 
and extent of practice involved, and provide recommendations regarding requirements

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108 College submission to the Australian Medical Council for Accreditation, May 2001, p68.
for ongoing assessment. The College also notifies the employing hospital and AMC in parallel with the medical board.\(^{109}\)

**Assessment of practice**

6.135 The Commission understands that a designated period of assessment of clinical practice is mandatory for all AON applicants undergoing a College specialist assessment.\(^{110}\)

6.136 The Commission understands that under the new AON process, the College will undertake ongoing assessment of the applicant after a defined period (initially 3 months and follow-up, as required, and after 12 months).\(^{111}\)

6.137 As is the case where a period of assessment is recommended for an overseas-trained practitioner seeking full recognition, the College requires that progress reports on the prospective AON practitioner be submitted by two nominated College Fellows, and that the practitioner register in the College’s ‘Maintenance of Professional Standards’ program. The College forwards the progress reports to the relevant medical boards.

6.138 Should the applicant’s practice be deemed unsatisfactory during the period of ongoing assessment the relevant State Medical Board may choose to withdraw or further limit the appointee’s registration.

**Fees for specialist assessment**

6.139 An applicant for specialist recognition is required to pay a fee to the College. The Commission is advised that as at January 2002, there are three categories of fees. The College initially charges an applicant $4,400 (Category 1 fee) for a documentary assessment and a face-to-face interview.

6.140 In addition, where an overseas-trained practitioner is required to undertake a period of on-site assessment, and the Fellows providing that oversight are located in the same workplace as the overseas-trained practitioner, the College charges $7,700 (Category 2 fee). Where the Fellows providing a period of oversight are located at another facility, the College charges $14,300 (Category 3 fee). Both categories of fee include the initial (Category 1) assessment fee of $4,400.

6.141 The Commission is advised that if an overseas-trained practitioner undertakes a period of assessment, it is likely that the Fellows overseeing the assessment will be located in the same hospital. Where the applicant is an AON appointee however, it is likely that one or more of the Fellows will be located off-site.

**OVERVIEW OF THE COLLEGE’S TRAINING AND ASSESSMENT**

6.142 An overview of the training and assessment processes of the College is provided in Figures 6.2 and 6.3 below.\(^{112}\)

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\(^{110}\) College submission to the Australian Medical Council for Accreditation, May 2001, p68.


\(^{112}\) Figures 4.2 and 4.3 compiled by the Australian Competition and Consumer Commission.
Figure 6.2: College surgical training system

Engaged as employee or contractor by public hospital.

‘Credentialing’ by hospitals (ie existing surgeons)
Practising rights in individual private hospitals.
Outside the application for authorisation.

SUPPLY OF SURGEONS — RACS Fellows
Other (eg overseas-trained area of need surgeons).

Advanced surgical training (4-6 years depending on speciality).
‘Part 2’ Exam in final year – set and conducted by RACS.
Practical training in hospital posts accredited by RACS.

Overseas-trained practitioners (see Figure 4.2).

‘Intermediate’ (ie ‘basic surgical registrars’ – continue to receive formal basic training for a limited period).
Advanced trainees selected by RACS.
Within the application for authorisation

Basic surgical training (2 years).
‘Part 1’ Exam in 2nd year – set and conducted by RACS.
Practical training in hospitals approved by RACS.
Number of trainees limited to reflect the availability of places on the basic training skills courses and the number of advanced surgical training places.
Basic trainees selected by RACS.
Outside the application for authorisation

Australian university medical graduates – apply to RACS program during internship.

66
Engaged as employee or contractor by public hospital.

‘Credentialing’ by hospitals (ie existing surgeons).

Practising rights in individual private hospitals.

Outside the application for authorisation

Within the application for authorisation

**SUPPLY OF SURGEONS — RACS Fellows**

- Period of onsite assessment (surgeon must apply for a position within hospital).

- Must win a place in either basic or advanced training program depending on College assessment (see Figure 6.1).

**Others (eg overseas-trained area of need surgeons).**

Depending on RACS recommendation:

- Period of onsite assessment (surgeon must apply for a position within hospital).

- Must win a place in either basic or advanced training program depending on College assessment (see Figure 6.1).

**State/Territory Medical Boards**
(typically accept RACS recommendations).

**Australian Medical Council (AMC)**
(administrative role only).

**Overseas-trained surgeons**

RACS makes recommendation.

AMC sends application to RACS for assessment.

RACS

Figure 6.3: College assessment procedure for overseas-trained surgeons
Appeal mechanisms

6.143 Any person adversely affected by a decision of the College referred to below may, within three months of receipt of notice of such decision, apply to the Chief Executive Officer to have the decision reviewed by an Appeals Committee of the College. An Appeals Committee may be convened in relation to the following decisions:

- decisions of the Censor-in-Chief’s Committee, Court of Examiners, Board of Basic Surgical Training, Surgical Boards, Regional Sub Committees of Surgical Boards or Supervisors of Surgical Training, in relation to the assessment of progress of Trainees of the College (including admission, dismissal or recognition of training);
- decisions of Boards and Committees in relation to applications for admission to Fellowship;
- decisions of the Censor-in-Chief and Surgical Board Chairman in relation to applications from overseas-trained practitioners for assessment for recognition on behalf of the AMC, or the New Zealand Medical Council, or any applicable State or Territory Medical Board (or for other appropriate purposes);
- decisions of the Censor-in-Chief and Surgical Board Chairman in relation to examinations or training required to be undertaken by overseas-trained practitioners for assessment;
- decisions of the Board of Continuing Professional Development and Recertification in relation to participation of the Recertification Program, and awarding of the Certificate of Continuing Professional Standards;
- decisions of the Council and Executive Committee of the College on the advice of the Censor-in-Chief’s Committee in relation to accreditation for training of hospitals, units, teaching centres or supervisors;
- decisions of the Complaints Committees – Council and Regional, in relation to their requirements that complainants be counselled, censured or have the complaint against them referred to Council pursuant to Article 30 of the Articles of Association;
- decisions of the Honorary Treasurer in relation to the financial status of Fellows, Trainees, or other persons; and
- such other decisions for the College, its Boards or Committees as the Council may determine from time to time.

6.144 An appeal may only be lodged on one or more of the following grounds:

- an error in law or in due process occurred in the formulation of the original decision;
- relevant and significant information, whether available at the time of the original decision or which became available subsequently, was not considered or not properly considered in the making of the original decision; and/or
- the original decision was clearly inconsistent with the evidence and arguments put before the body making the original decision.
6.145 The College submits that it is rare for hospitals to appeal against a decision not to accredit a post or a decision to disaccredit a post. The reason being that it works in collaboration with the hospitals to ensure standards are met for each post.113

6.146 The Appeals Committee consists of the following members:

- the Vice President of the College or another Councillor appointed by the Council;
- two Fellows of the College (from a surgical sub-speciality not involved in the subject matter of the appeal); and
- two other appropriately qualified persons who are not Fellows of the College.

6.147 A non-Fellow member of the appeals committee, usually a senior lawyer, chairs the Committee. Additionally, any individual who was party to the decision of the College to which the appeal relates is not permitted to sit on the Appeals Committee.

6.148 The Appeals Committee operates in accordance with the rules of natural justice and decides each application on its merits. The Committee is conducted informally, is not bound by the rules of evidence, and may invite any person to appear before it or to provide information.114

6.149 An applicant to the Appeals Committee has the right to appear before the Appeals Committee. However, an applicant is not entitled to have an advocate or be legally represented unless the Committee has given its consent.

6.150 In addition, the applicant may be required, before an Appeals Committee is convened, to pay a fee of such an amount as determined by the Council of the College. In the absence of a decision to the contrary, an applicant may also be liable for the costs associated with convening the appeal including, travel, accommodation, honoraria and recording costs. The Appeals Committee may recommend to the Council that some or all of the costs be waived.

6.151 Upon consideration of the information, an Appeals Committee may:

- confirm the decision which is the subject of the appeal;
- revoke the decision which is the subject of the appeal;
- revoke the decision and refer the decision to the relevant Board or Committee for further consideration (upon such terms or conditions determined by the Committee);
- revoke the decision and make recommendations to Council on an alternative decision; and
- recommend to the Council whether part or all the costs associated with the Appeals Committee should be waived.

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113 College submission in support of the application, March 2001, p32.
Statistical overview of College training and assessment procedures

Trainees

6.152 As reported in February 2002, there were approximately 1510 trainees registered with the College, 771 of which are registered in the basic surgical training program and 739 trainees have proceeded to the advanced surgical training in one of nine surgical specialities. In addition, there were 22 ‘endorsed’ trainees, who have already completed a Fellowship but are training for another specialty.\footnote{115}

Assessment of trainees

6.153 The following tables present the results of the College’s Part 1 (Basic Training) Examinations and Part 2 (Fellowship) Examination for the past five years. The Part 1 exam consists of a multiple choice exam and an objective structured clinical exam.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
\hline
Total registered & 378 & 383 & 369 & 460 & 488 & 451 \\
\hline
Total passed & 129 & 206 & 105 & 218 & 194 & 122 \\
\hline
\% passed & 38 & 60 & 32 & 51 & 44 & 32 \\
\hline
Total failed & 213 & 141 & 219 & 208 & 242 & 263 \\
\hline
\% failed & 62 & 40 & 68 & 49 & 56 & 68 \\
\hline
Total no-attendance & 36 & 36 & 45 & 34 & 52 & 66 \\
\hline
\end{tabular}
\caption{Result of the Part 1 Multiple Choice Exam from 1995 – 2000\footnote{116}}
\end{table}

6.154 Table 6.4 below demonstrates that during the period from 1995 to 2000, the pass rate in the Part 1 Structured Clinical Examination has been considerably higher than that of the Multiple Choice Exam. In particular, from 1996 to 1999 approximately 80% of trainees sitting the Part 1 clinical exam passed that exam. This number rose to 90% in 2000.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
\hline
Total registered & 215 & 231 & 213 & 190 & 288 & 242 \\
\hline
Total passed & 121 & 172 & 157 & 149 & 220 & 205 \\
\hline
\end{tabular}
\caption{Result of the Part 1 Objective Structured Clinical Examination 1995 – 2000\footnote{117}}
\end{table}

\footnote{115}{Source: Australian Medical Council Accreditation Review, Royal Australian College of Surgeons, February 2002.}
\footnote{116}{College submission to the Australian Medical Council for Accreditation, May 2001, Attachment 35.}
\footnote{117}{Ibid}
Table 6.5 below shows the number of advanced surgical trainees who passed the Part 2 Fellowship Examination increased slightly from 72% in 1999 to 74% in 2000. The College advises that a total of 531 candidates presented for the Fellowship Examination during May 1995 to May 1998. Of this number, there were 183 General Surgical trainees, 126 Orthopaedic trainees, 42 Plastic and Reconstructive surgery trainees, 27 Cardiothoracic trainees, 50 Otolaryngology trainees, 28 Neurosurgical trainees, 22 Paediatric surgical trainees, 49 Urological trainees and 4 Vascular Surgical trainees. Of the 531 candidates:

- 390 candidates passed at the first attempt;
- 75 candidates passed at the second attempt;
- 15 candidates passed at the third attempt;
- 4 candidates passed at the fourth attempt;
- 1 candidate passed at the fifth attempt; and
- 1 candidate passed at seventh attempt.

<table>
<thead>
<tr>
<th>% passed</th>
<th>62</th>
<th>80</th>
<th>78</th>
<th>81</th>
<th>80</th>
<th>90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total failed</td>
<td>73</td>
<td>44</td>
<td>44</td>
<td>35</td>
<td>56</td>
<td>24</td>
</tr>
<tr>
<td>% failed</td>
<td>38</td>
<td>20</td>
<td>22</td>
<td>19</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Total non-attendance</td>
<td>21</td>
<td>17</td>
<td>12</td>
<td>6</td>
<td>12</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 6.5: Result of the Part 2 Fellowship Exam 1995 – 2000

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total registered</td>
<td>165</td>
<td>166</td>
<td>198</td>
<td>205</td>
<td>216</td>
<td>189</td>
</tr>
<tr>
<td>Total passed</td>
<td>127</td>
<td>124</td>
<td>134</td>
<td>148</td>
<td>154</td>
<td>135</td>
</tr>
<tr>
<td>% passed</td>
<td>77</td>
<td>78</td>
<td>70</td>
<td>73</td>
<td>72</td>
<td>74</td>
</tr>
<tr>
<td>Total failed</td>
<td>37</td>
<td>36</td>
<td>57</td>
<td>55</td>
<td>59</td>
<td>48</td>
</tr>
<tr>
<td>% failed</td>
<td>23</td>
<td>22</td>
<td>30</td>
<td>27</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>Total non-attendance</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

118 College submission to the Australian Medical Council for Accreditation, May 2001, Attachment 34.
119 College submission to the Australian Medical Council for Accreditation, May 2001, Attachment 35.
Table 6.6: Average number of months taken to enter advanced surgical training after completing basic surgical training in Australia, per sub-specialities in 2001

<table>
<thead>
<tr>
<th>Surgical sub-speciality</th>
<th>Number of months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic</td>
<td>32*</td>
</tr>
<tr>
<td>General surgery</td>
<td>9</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>12</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>19</td>
</tr>
<tr>
<td>Otolaryngology – head and neck surgery</td>
<td>16</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>25</td>
</tr>
<tr>
<td>Urology</td>
<td>22</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>41</td>
</tr>
</tbody>
</table>

*There was only one cardiothoracic surgical trainee during this period.

Accreditation of hospital training posts

6.156 In 2001 there were 35 hospitals accredited for basic surgical training in NSW, 22 in Victoria, 16 in Queensland and 3 in South Australia, Western Australia and Tasmania.121

6.157 Table 6.7 shows that the disciplines with the largest number of advanced training positions are general surgery (212) and orthopaedic surgery (133).

Table 6.7: Advanced surgical training positions per surgical sub-speciality for each state and territory, 2001

<table>
<thead>
<tr>
<th>Surgical Speciality</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>SA</th>
<th>WA</th>
<th>TAS</th>
<th>NT</th>
<th>ACT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>78</td>
<td>59</td>
<td>38</td>
<td>14</td>
<td>14</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>212</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>9</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>13</td>
<td>8</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>46</td>
<td>31</td>
<td>27</td>
<td>9</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>133</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>13</td>
<td>13</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>46</td>
</tr>
<tr>
<td>Paediatric</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Plastic</td>
<td>16</td>
<td>17</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>46</td>
</tr>
</tbody>
</table>

120 The figures in Table 6.6 were compiled by the Commission from Attachment 1 to the College’s submission, 14 March 2002.
121 College submission to the Commission, 14 March 2002, pp1, 4 and 5.
With regard to accreditation of hospital posts for advanced surgical training, the College considered the accreditation and re-accreditation of 144 hospital posts (involving 41 hospitals) in 1999. Of these, 3 posts had their accreditation withdrawn and 1 new post was not accredited. In 2000, 63 posts were considered (involving 41 hospitals). Of these, accreditation was withdrawn for 1 post and 2 new posts were not accredited.123

In 2001, the College assessed 175 Advanced Surgical Training posts. Of these, 172 were approved, 2 posts were inspected and declined and 1 post was disaccredited. Specifically, one Cardiothoracic Surgery training post at Geelong Hospital was declined accreditation due to insufficient case load and inadequate supervision. Another general surgical training post at Whyalla Hospital was declined due to insufficient case load, inadequate supervision and insufficient Junior Surgical Resident staff. The Plastic and Reconstructive training post at Canberra Hospital was disaccredited for the same reasons identified at Whyalla Hospital. The Commission is also advised that a number of surgical specialities conduct inspections every five years, and of the 175 posts inspected in 2001, 105 were in Orthopaedics.124

Queensland Health submits that a number of non-accredited training positions have been converted into accredited training positions in recent years.125 Hospitals containing both accredited and non-accredited posts in Queensland include:

<table>
<thead>
<tr>
<th>Hospital/sub-speciality</th>
<th>Accredited</th>
<th>Non-accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cairns:</strong> Orthopaedics</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Gold Coast:</strong> General surgery</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Logan:</strong> General surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

123 1999 and 2000 accreditation figures are sourced from the RACS letter to the Commission, dated 30 April 2001, p.2.  
124 The information contained in this paragraph is source from the College’s submission to the Commission, 14 March 2002, p.1.  
126 Ibid, Attachment.
Table 6.8: Accredited and non-accredited training posts in Queensland public hospitals

<table>
<thead>
<tr>
<th>Hospital/sub-speciality</th>
<th>Accredited</th>
<th>Non-accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mater:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Princess Alexandra:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>QEII:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Royal Brisbane Hospital:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Rockhampton:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Townsville:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

6.161 Data provided to the Commission by NSW Health indicates that approximately 71% of funded surgical registrar positions are accredited.\(^{127}\) The proportion of accredited positions varies across the surgical specialities. Specifically, the highest proportion of positions accredited are in urology, ear nose and throat, vascular and paediatric surgery (100%), while the lowest proportion of accredited positions occurred in orthopaedic surgery (56%). There are presently an estimated 25 funded non-accredited general surgical positions and 30 funded non-accredited orthopaedic positions within the NSW public hospital system. The estimated number of accredited and non-accredited surgical training positions in NSW public hospitals is summarised in Table 6.9.

Table 6.9: Accredited and non-accredited training posts in New South Wales public hospitals

\(^{127}\) Positions which are currently non-accredited may be so because the College has not been asked to accredit them (NSW Health submission April 2002).

\(^{128}\) NSW Department of Health submission to the Commission, April 2002, Appendix A.
<table>
<thead>
<tr>
<th>Sub-speciality</th>
<th>Accredited registrar positions</th>
<th>Non-accredited registrar positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic Surgery</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>ENT</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>38</td>
<td>30</td>
</tr>
<tr>
<td>Paediatric</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Plastic and reconstructive</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>General Surgery</td>
<td>71</td>
<td>25</td>
</tr>
<tr>
<td>Urology</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>177</td>
<td>68</td>
</tr>
</tbody>
</table>

6.162 The Commission is advised that as at September 2002 there were a total of 42 service registrar posts in Western Australia (that is, non-accredited surgical training posts). These posts were in general surgery, cardiothoracic surgery, neurosurgery, plastic surgery and vascular surgery. The Commission is also advised that as at 1 July 2001, there were 15 accredited surgical training positions in the ACT. At the same time, there were 5 non-accredited surgical training positions in the ACT.

Assessment of overseas-trained surgeons

6.163 The College receives applications from overseas-trained practitioners for assessment throughout the calendar year. In 2000, the College received 80 such applications. There were 21 interviews and assessments conducted in 2000 and 40 in 2001. The interviews and assessments involved the following specialities:

Table 6.10: The number of interviews of overseas-trained surgeons conducted in 2000 and 2001, per surgical specialty

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>23</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>16</td>
</tr>
<tr>
<td>Otolaryngology - Head and Neck Surgery</td>
<td>10</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>4</td>
</tr>
</tbody>
</table>

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129 The Western Australian Minister for Health, the Hon Bob Kucera, submission to the Commission, 18 September 2002, p2.
130 Submission from ACT Department of Health, Housing and Community Care, 28 September 2001.
131 Unless otherwise stated, the figures appearing under this heading were provided by the College in its submission dated 14 March 2002, pp 6-12.
6.164 Between January 1993 and March 2001, 297 applications for assessment were received from overseas-trained surgeons. Table 6.11 provides a breakdown of this figure:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>4</td>
</tr>
<tr>
<td>Vascular</td>
<td>2</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>1</td>
</tr>
<tr>
<td>Plastic and Reconstructive Surgery</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6.11: Results of assessment of overseas-trained practitioners, 1993-2001.\(^{132}\)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications approved</td>
<td>37</td>
</tr>
<tr>
<td>Applications rejected</td>
<td>11</td>
</tr>
<tr>
<td>Further training required and/or examination</td>
<td>89</td>
</tr>
<tr>
<td>Applications awaiting College assessment or are required to submit further information</td>
<td>93</td>
</tr>
<tr>
<td>Applications withdrawn</td>
<td>35</td>
</tr>
<tr>
<td>Applications lapsed</td>
<td>32</td>
</tr>
</tbody>
</table>

6.165 In 2000 and 2001, 61 interviews and assessments of overseas-trained surgeons were conducted in 2000 and 2001. Table 6.12 shows the number of months taken to complete these assessments.

Table 6.12: Number of months taken to complete interviews and assessment of overseas-trained surgeons in 2000 and 2001.\(^{133}\)

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed within 3 months</td>
<td>7</td>
</tr>
<tr>
<td>Completed within 3-6 months</td>
<td>12</td>
</tr>
<tr>
<td>Completed within 6-9 months</td>
<td>13</td>
</tr>
<tr>
<td>Completed within 9-12 months</td>
<td>20</td>
</tr>
<tr>
<td>Completed after 12 months</td>
<td>9</td>
</tr>
</tbody>
</table>

6.166 The Commission is advised that the remaining 19 overseas applicants had not completed the requisite application procedures of the College or the Australian Medical Council or had withdrawn their application for assessment.\(^{134}\)

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\(^{132}\) Australian Medical Council submission to the Commission, May 2001, Table 2, p7.

\(^{133}\) College submission, March 2002, p7.

\(^{134}\) Ibid.
Applications were received from 26 different countries in 2000. In particular, the countries where applicants completed the most recent training, and the number of applicants from each country are set out in Table 6.13 below.

**Table 6.13: The number of applications for assessment from overseas-trained surgeons in 2000, by country of origin.**

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>20</td>
</tr>
<tr>
<td>South Africa</td>
<td>9</td>
</tr>
<tr>
<td>India</td>
<td>8</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>6</td>
</tr>
<tr>
<td>Egypt</td>
<td>5</td>
</tr>
<tr>
<td>USA</td>
<td>4</td>
</tr>
<tr>
<td>Iraq</td>
<td>3</td>
</tr>
<tr>
<td>Pakistan</td>
<td>3</td>
</tr>
<tr>
<td>China</td>
<td>2</td>
</tr>
<tr>
<td>Poland</td>
<td>2</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2</td>
</tr>
<tr>
<td>Sweden</td>
<td>2</td>
</tr>
<tr>
<td>Austria</td>
<td>1</td>
</tr>
<tr>
<td>Bosnia</td>
<td>1</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>1</td>
</tr>
<tr>
<td>Burma</td>
<td>1</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>1</td>
</tr>
<tr>
<td>Germany</td>
<td>1</td>
</tr>
<tr>
<td>Israel</td>
<td>1</td>
</tr>
<tr>
<td>Malaysia</td>
<td>1</td>
</tr>
<tr>
<td>Mexico</td>
<td>1</td>
</tr>
<tr>
<td>Russia</td>
<td>1</td>
</tr>
<tr>
<td>Sudan</td>
<td>1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>1</td>
</tr>
<tr>
<td>Turkey</td>
<td>1</td>
</tr>
</tbody>
</table>
6.168 A summary of the College recommendation made for each of the above listed applications appears at Attachment B to this draft determination.