EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

The College has emphasised that the next few years will be a period of transition in selection and in the introduction of new assessment methods. The transition process is complex and was not well

understood by employing authorities or by a significant proportion of fellows, despite the College's considerable efforts to communicate.

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

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

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

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

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

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

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

Commendations

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

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

C The Memoranda of Understanding and Service Agreements developed between RACS and the specialty societies in relation to education and training roles and responsibilities.

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

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

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

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

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

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

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

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

L The College's annual Activities Report.

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

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

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

P RACS' commitment to renewing its support for supervisors.

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

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

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

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

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

Recommendations

That RACS:

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

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

3 While recognising the inherent difference between specialties, continue to ensure greater coherence in key training processes. When differences continue between specialties in

selection processes, assessment and components of training, RACS should ensure that they are supported by a clear evidence-based educational rationale.

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

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

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

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

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

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

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

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

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

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

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

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

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

16 *Research thoroughly the strengths, weaknesses, practicalities and generalisability of Mini-CEX and DOPS as assessment tools in the local hospital setting and make public its findings.*

17 *Report in annual reports on the AMC on the procedures for identification and management of underperforming trainees.*

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

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

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

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

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

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

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

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

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

27 *Report in annual reports to the AMC on:*

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

28 *Increase communication with supervisors and trainers about SET.*

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

Recommendations on accreditation

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

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

The Specialist Education Accreditation Committee recommends:

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

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

(i) Mechanisms agreed with jurisdictions to facilitate resolution of issues of concern, including workforce numbers

(ii) The development and implementation of an enhanced strategy for communication with stakeholders about SET

(ii) Evaluation of the selection process

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

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

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

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

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

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