

RACS Trainees' Association End-of-Term Survey

An analysis of 5 years of data

2010 - 2015



RACSTA

Your Trainees' Association



RACSTA Chair's Message

What does it mean to improve training for a generation of surgeons? The release of five years of surgical trainee survey data gives RACSTA, RACS, and the entire surgical profession an opportunity to reflect on progress that has been made towards excellent training, and take stock of the challenges that remain to be tackled.

In looking at the data entrusted to us by surgical trainees, it's important to thank our fellow trainees for filling in these surveys, and acknowledge that these data belong to the trainees. No other postgraduate medical specialty in New Zealand and Australia has such a detailed longitudinal snapshot of the issues affecting training, and we are not aware of any more comprehensive survey data on surgical training internationally. Covering nine specialties in two countries over half a decade, we are pleased to present this report, which we believe is a unique contribution to a modern understanding of what it means to train as a surgeon.

Change requires commitment at both a personal and system-wide level. In a culture of mutual respect, everyone has responsibilities. This doesn't minimise the importance of dismantling oppressive systems, but it is a prerequisite for participation in a workforce with high stress, high stakes, with both the lives of patients and the well-being of our colleagues on the line.

One of the emerging challenges in surgical training is that as consultants are told they must not engage in belittling or discriminatory behaviour, they lose confidence as educators. How does one give feedback when one is frightened of being accused of bullying? Trainees are reporting a concern that the anti-bullying messages are eclipsing feedback. Here, too, formal training is required. How to give and receive feedback is a competency that is learned. And it needs to be taught. Ideally, feedback should be given frequently, not only when a trainee is underperforming or when their career is circling the drain. Feedback needs to be timely, and engage the learner. While a growing number of surgeons are undertaking higher degrees in surgical education, the vast majority of surgical supervisors have no formal teacher-training. And this is why the Foundation Course for Surgical Educators is so important. The Foundation Course arose in part based on a recommendation RACSTA made to the Expert Advisory Group on Discrimination, Bullying and Sexual Harassment, and it's a privilege to be a member of a college which is taking change seriously and providing structured learning experiences to strengthen our profession.

My hope is that one day the surgical profession will be as diverse as the communities we serve. This will enable us to do the most good for our patients and to draw on the best and brightest from New Zealand and Australia. But this diversity and strength will only come if we commit to a rigorous assessment of our own professionalism and of the structures in which surgical training occurs. We submit this report as a way of deepening of the conversation about what excellence in surgery means for every surgeon, trainee, and ultimately, each patient.



Dr Ruth Mitchell
Chair, RACSTA

Executive Summary

The RACS Trainees' Association (RACSTA) has surveyed Surgical Education and Training (SET) trainees in clinical posts every six months since term 2, 2010 (surveys were not conducted for either rotation in 2011).

This report presents amalgamated data from survey results over five years, from the 2010 term 2 rotation to the 2015 term 2 rotation.

The survey has been conducted nine times. More than 20% of trainees (2,660 responses from roughly 12,500 trainees in clinical posts in this period) have participated. Trainees who spent two six-month rotations in the same post were sent the survey twice. There are no known similar surveys conducted by surgical trainee associations internationally, so comparing response rates is difficult.

Participation in the RACSTA survey has almost doubled since the end of the reporting period for this survey. This significant increase – from more than 20% in 2015 to more than 40% in 2016 of eligible trainees – aligns with the release of the RACS Expert Advisory Group report into bullying, discrimination and sexual harassment in surgery in 2015 and the subsequent publication by RACS Council of the Action Plan: *Building Respect and Improving Patient Safety*. Data from 2016 survey results is not included in this five year survey result. Consistent with the findings of published EAG research, it is likely that this report reflects under-reporting from 2010 – 2015 of concerns and issues in the years preceding the EAG.

The SET training program transitioned from previous training models in 2008 and there have been material changes to it over the last decade. Since 2013, there has been further devolution of administration of the individual training programs from RACS to 11 of the 13 specialty societies and associations. During the period, RACS has also developed a range of principles-based policies that have impacted on the implementation of the SET program and therefore of Trainee experiences. Through a variety of partnering agreements, the societies and associations now have greater freedom to determine the structure of each SET program than in previous years. As a result, there is a wider variation between SET programs in duration, requirements and assessment than was the case in 2008. Despite this variability of training programs, there is broad consistency in Trainee feedback about their experiences across different programs. This suggests that issues faced by Trainees in one specialty are shared by others. In the months ahead, RACSTA will publish specialty-specific survey results, to enable detailed analysis and identify any specialty specific issues and learnings.

Survey results demonstrate that in general, trainees believe Specialty Training Boards (STB) provide quality education and training for their trainees. RACSTA applauds STBs for this. RACSTA encourages STBs to view these survey findings as an opportunity to better understand the Trainee experience, and use it to improve and progress excellence in SET.

Key Issues

The data in this report are detailed and extensive. Issues identified can be broadly categorized into four broad themes: the quality and scope of the education and training provided by each unit; opportunities for flexible training; exposure to bullying and harassment and; industrial relations issues.

Education and Training

Surgical units with accredited posts are required to demonstrate they can provide the appropriate level of education and training. This requirement is built into partnering agreements between STBs and RACS, and must meet Australian Medical Council (AMC) accreditation standards. These are set on behalf of the New Zealand Medical Council (NZMC) and the Medical Board of Australia (MBA). It is advantageous for a surgical unit to have an accredited registrar allocated as they can provide a greater level of surgical skill and team leadership.

The survey results demonstrate that a number of factors negatively impact on the quality of education and training provided to Trainees. These include: ineffective supervision, lack of access to operative and outpatient clinics due to unit rosters or presence of fellows/other Trainees, no provision of formal teaching within the hospital or predominately service provision.

While the survey results show the majority of accredited training posts are providing good training, it is also clear that there is room for improvement. RACSTA believes the STBs should continue their commitment to these improvements. More specifically, we encourage the supervisors and trainers working in surgical units to take ownership of the challenges identified in this report and make the changes and improvements necessary to produce not just competent, but excellent surgeons into the future.

Almost 50% of Trainees thought they were not provided with enough acute operative exposure [figure 16]. They reported that when they did attend acute lists, they felt supported by Consultants for decision making and operative training [figure 17, 18]. However, in Figure 19 half of all respondents felt that the training they received while in the acute setting was between fair and very poor. Limited supervision in the acute setting or the disinterest of attending consultants can lead to Trainees missing out on education and training opportunities whilst they are providing valuable service. The negative impact on the trainee experience of poor supervision was a common theme in responses. This is reflected in the 'free text' comments across all surveys.

Participation in outpatient clinics is a requirement for AMC accreditation. More than 60% of trainees thought outpatient clinics provided good learning opportunities [figure 23]. Survey results indicate that this appears to be largely self-directed. Figure 29 shows more than 50% of trainees rarely or never had a consultant use an outpatient case for teaching purposes. A further 30% said that this only happened sometimes. In-hospital surgical training has a symbiotic relationship with the service component of the job. RACSTA believes that when only 20% reporting receiving regular training in this core component of surgical practice, the quality of training posts can be improved.

Trainees report that the presence of fellows and other unaccredited registrars has in some units, been a barrier to education and training. The impact of fellows on training may depend on the SET level and previous experience of the Trainee in a given unit. This has been explored in Wilson Petrushnko's (et.al.) study to quantify the impact of fellows on training in Australia and New Zealand¹. Of the Trainees surveyed by RACSTA, 60% found the presence of a fellow in the unit was a barrier to their own learning experience. Many other Trainees found the fellow they worked with to be helpful and a benefit in training. RACSTA believes that STBs face a challenge in ensuring the presence of other fellows and non-accredited trainees on units does not impede the quality of training for 60% of Trainees.

¹ Petrushnko, W (et. al.), The impact of fellowships on surgical resident training in a multispecialty cohort in Australia and New Zealand, *Surgery: Official Journal of the Society of University Surgeons, Central Surgical Association, and the American Association of Endocrine Surgeons*, 2015-12-01, Volume 158, Issue 6, Pages 1468-1474

Flexible Training

Very few trainees report having completed any of their training in a flexible or part-time manner. Although some SET programs are progressively becoming competency based, some specialties are still more time-orientated in their requirements. Typically, part-time training has been regarded as a mathematical equation (2 x rotation at 0.5FTE = 1 x rotation at 1 FTE). These results indicate there has been limited acceptance in units/ the profession that different models of flexible training are possible. In contrast, nearly 30% of trainees report an interest in pursuing flexible training options [figure 3].

RACS 2017 Diversity Plan commits the College to eliminating the structural impediments and ensuring there are other than full-time training options. RACSTA hopes that this commitment will make flexible training widely accessible to Trainees in the years ahead support the diversification of the surgical workforce and improve access to surgical training by highly qualified individuals who are currently deterred by this barrier.

Bullying and Harassment

The data in this report indicate that bullying and harassment in surgery affects more than 18% of trainees. This rate may appear lower than the 63% reported in the EAG report, but the RACSTA survey gives an indication of six-month incidence rates, whereas the EAG report details a prevalence rate. Moreover, given the 2010 – 2015 reporting period for this survey, RACSTA believes there may be under-reporting of these issues by Trainees in the period before the EAG drew attention to the incidence of these issues in surgery. This is aligned with the EAG's findings that Trainees fear the consequences on their career and training opportunities of reporting inappropriate behaviour.

An extensive program of work is mapped out in RACS Action Plan: *Building Respect and Improving Patient Safety*. RACSTA fully supports this and applauds RACS for investing the time, effort and resources into identifying these problems, and committing to doing something about them. Supporting cultural change in the profession, and requiring all surgeons to identify and call out inappropriate behavior as a means of ending it, will over time substantially improve the learning experience of Trainees.

Industrial Relations Issues

Working hours vary between countries and states. Trainee feedback indicates that there are issues with both too many and too few working hours. Table 17 demonstrates that more 30% of Trainees believed that they were fatigued or that patient safety was compromised as a result of their working hours. Trainee reports of hours at work and on-call hours are shown in Figures 11-15 and Table 12. The majority of Trainees report they work between 50-70 hours per week (excluding on-call). Most trainees feel that the number of hours they work is appropriate for the training experience they require to obtain FRACS. A frequently repeated comment in the free-form sections of the survey, is that excessive on-call work results in fatigue and that overtime was often unpaid. With regard to fatigue, it is recognized that this is part of working as a doctor, but how fatigue is managed is very important.

Trainees are allocated to accredited training posts by Specialty Training Boards, but are employed by different jurisdictions. As a result, some trainees in some specialties are frequently re-located between employers and also between countries and states. Some Trainees are frequently required to relocate and in the process, lose employment benefits. Others are able to stay within the health network for the duration of their training. RACSTA acknowledges that STBs are not able to dictate employment conditions. However, we believe there is a compelling argument for issues such as accommodation and the transfer of employment benefits between health networks, to be integrated with the hospital post accreditation process.

Actions and Opportunities

There are many opportunities available for STBs to improve the quality of surgical education and training. Surgical training will need to continue to adapt to the external environment in which it is conducted. This means continuing to move away from historical training models and towards learning frameworks that reflect contemporary educational principles and current community expectations. RACS is well placed to lead the way in developing creative ways to employ and train the surgeons of the future without compromising the quality of training.

STB's must continue to champion cultural change in surgery and ensure all those involved in SET have completed not just the mandatory courses, but others that may improve their educational skills. Feedback, both good and bad, must become a regular and accepted part of training, and not just an end of term experience. If a training post is not delivering a high quality educational experience, then the STB should review and consider disaccrediting the post. This will make clear that SET Trainees are not just there to provide service for the hospital, but become confident, independent surgeons.

The insights entrusted to RACSTA by five years of trainees through this end of term survey affirm the advocacy directions undertaken by RACSTA. It is clear that trainees want greater flexibility in their training environment, that there is still work to do on improving the culture in which training occurs, and that regular feedback is important. These data support the initiatives taken by RACSTA, and in the rapidly changing surgical workplace, we believe there is an increasing opportunity for the needs of trainees to be met.

Areas which trainees have clearly identified where value can be added to training include those most crucial encounters – with the patient in clinic, and the patient in the operating theatre. While both of these environments are already the site of rich learning, the self-directed nature of clinic encounters for most trainees suggests this venue has been under-utilised for training. And while the primary aim of operative surgery is to provide a service to the patient, more work must be done to ensure that operating theatre experiences are also of maximum training benefit for the surgeons of tomorrow.

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This report is for use by RACS Boards and Committees only. Further reports and data will be compiled for public release in the future.

Demographics

The RACSTA End of Rotation survey was completed 2,660 by Trainees between Term 2 2010 and Term 2 2015 (some trainees may have completed the survey multiple times). There were approximately 12,500 trainees who could have completed it.

Table 1: Response rate

Survey Period	Number of Respondents
Term 2 2010	157
Term 1 2012	325
Term 2 2012	446
Term 1 2013	463
Term 2 2013	307
Term 1 2014	224
Term 2 2014	235
Term 1 2015	228
Term 2 2015	275
Total	2660

Gender

Gender statistics were not collected until Term 2 2014 so no comment has been made about this.

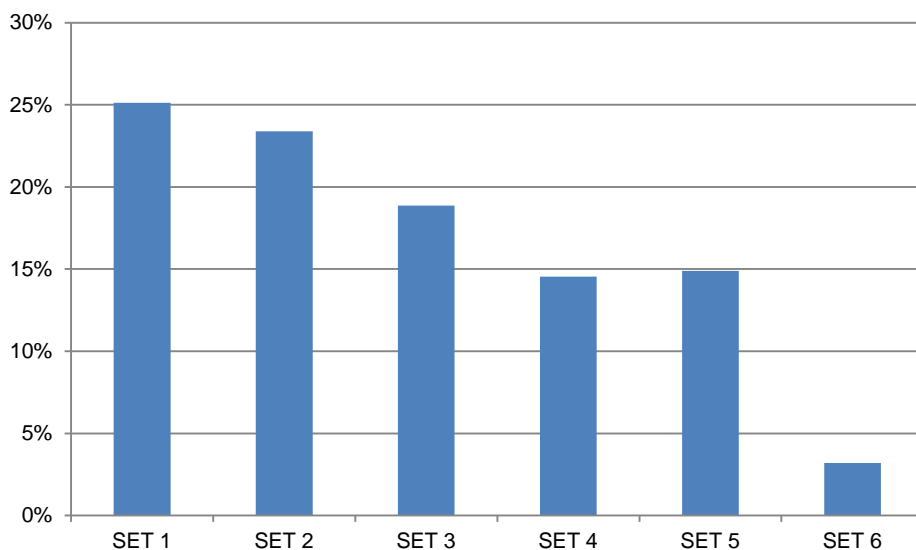
PGY Level

PGY statistics were not collected until Term 2 2014 so no comment has been made about this.

SET Level

Total number of all Trainees to answer this question: 2,660. This refers to the SET level of the Trainee at the time they completed the survey.

Figure 1: SET Level of Trainees



Time on team

Table 2: Time on team

Time (months)	Number of Respondents	1	2	3	4	5	6
All Specialties	2,169	0.3%	0.9%	5.2%	2.5%	0.9%	90.2%
Cardiothoracic Surgery	53		3.8%	5.7%			90.6%
General Surgery	993	0.5%	0.4%	4.8%	1.5%	1.1%	91.6%
Neurosurgery	108		1.9%	0.9%	2.8%		94.4%
Orthopaedic Surgery	346		1.7%	7.2%	7.8%		83.2%
OHNS	172	0.6%	0.6%		1.7%	2.3%	94.8%
Paediatric Surgery	70		2.9%	10.0%	1.4%	2.9%	82.9%
Plastic Surgery	157		0.6%	3.8%	3.2%	0.6%	91.7%
Urology	193		0.5%	11.9%			87.6%
Vascular Surgery	77	1.3%	1.3%			1.3%	96.1%

As seen in Table 2, most respondents completed a 6-month rotation. Some trainees completed a 3 month rotation with others moving between teams within a unit.

Location

Total number of all Trainees to answer this question: 2,634

Figure 2: Location of rotation



The region in which responding trainees were located for each survey is seen in Figure 2. This is representative of the spread of training posts throughout the 5 years (NSW/ACT 32%, NZ 14%, QLD 16% SA 6%, VIC/TAS, 25%, and WA 7%).

Part-time training

I worked full-time or part-time

Table 3: Full time status

	Number of Respondents	Full-Time	Part-Time
All Specialties	2660	99.2%	0.8%
Cardiothoracic	68	98.5%	1.5%
General Surgery	1200	99.2%	0.8%
Neurosurgery	129	99.2%	0.8%
Orthopaedic	429	99.5%	0.5%
OHNS	210	99.0%	1.0%
Paediatric	89	100.0%	
Plastic Surgery	206	99.5%	0.5%
Urology	232	99.1%	0.9%
Vascular	97	99.0%	1.0%

Interested in flexible training

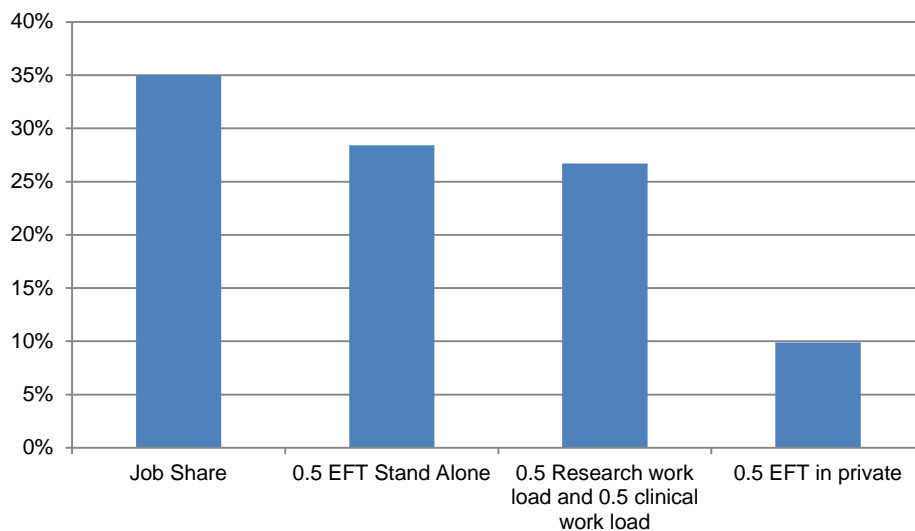
Table 4: Flexible training interest

	Number of Respondents	Yes	No
All Specialties	2503	28.3%	71.7%
Cardiothoracic	63	30.2%	69.8%
General Surgery	1124	30.6%	69.4%
Neurosurgery	125	18.4%	81.6%
Orthopaedic	405	20.9%	79.1%
OHNS	198	31.3%	68.7%
Paediatric	86	45.3%	54.7%
Plastic Surgery	196	32.1%	67.9%
Urology	212	25.0%	75.0%
Vascular	92	21.7%	78.3%

Part Time Job Model Preferences

Total number of all Trainees to answer this question: 1161

Figure 3: Part-time job model preferences



As can be seen in Table 3, 99% of all trainees are employed on a full time basis for their clinical training, while on average nearly 30% have expressed an interest in participating in some model of flexible training. Figure 3 demonstrates that there is interest in at least four different models, with job share being the most frequent preference expressed.

Comments

A summary of the comments about other Part-Time options include:

- ❖ *Current structures could support a 0.5 EFT stand-alone position*
- ❖ *0.7 or 0.8 EFT stand-alone would be preferable, such as working a four day week.*
- ❖ *Work a four day week, with each day being 10 hours long*
- ❖ *Time is needed to study for exams*
- ❖ *Six months on, six months off is a possibility*

Accommodation

Provided with accommodation

Respondents were asked whether they were provided with any accommodation while they were on rotation. The majority of Trainees are not provided with accommodation as can be seen in Table 5.

Table 5: Accommodation

	Number of Respondents	Yes	No
All Specialties	2477	16.3%	83.7%
Cardiothoracic Surgery	60	3.3%	96.7%
General Surgery	1115	25.7%	74.3%
Neurosurgery	121	0.8%	99.2%
Orthopaedic Surgery	404	14.6%	85.4%
OHNS	198	3.5%	96.5%
Paediatric Surgery	85	7.1%	92.9%
Plastic Surgery	193	1.0%	99.0%
Urology	212	17.5%	82.5%
Vascular Surgery	89	3.4%	96.6%

Problems with accommodation

Individuals who indicated that they were provided with accommodation while they were on rotation were asked whether they experienced any problems with that accommodation. Of the 322 responses seen in Table 6, an average of 25% answered that they experienced problems with accommodation. As hospitals with accredited posts that provide accommodation are most often rural areas, not all specialties allocate to these areas. Trainees in General Surgery, Orthopaedic Surgery and Urology are most likely to be allocated to a rural/non-metropolitan hospital.

Table 6: Accommodation Issues

	Number of Respondents	Yes	No
All Specialties	322	25.8%	74.2%
Cardiothoracic Surgery	1		100.0%
General Surgery	228	24.1%	75.9%
Neurosurgery	1	100.0%	
Orthopaedic Surgery	49	24.5%	75.5%
OHNS	7	42.9%	57.1%
Paediatric Surgery	3	66.7%	33.3%
Plastic Surgery	1		100.0%
Urology	31	32.3%	67.7%
Vascular Surgery	1		100.0%

Comments

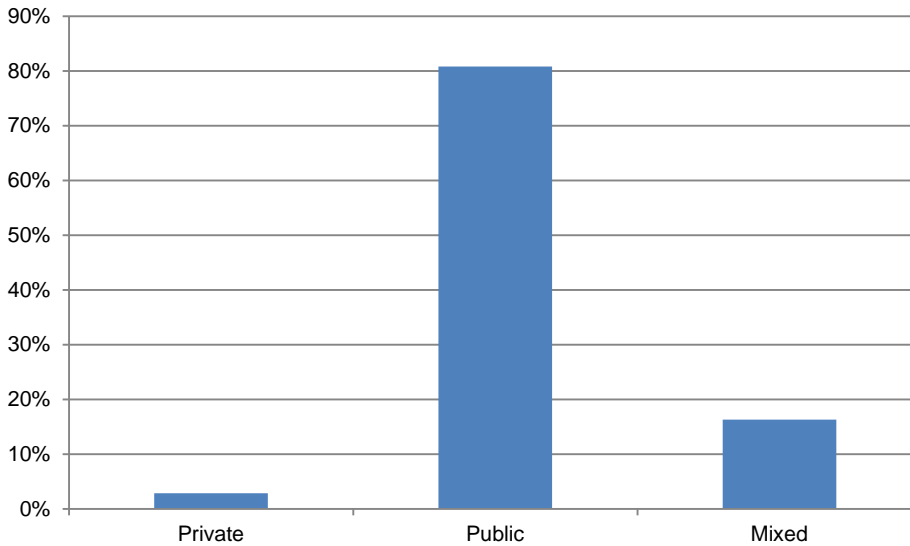
The most common comment from Trainees about accommodation issues was that the appliances provided with accommodation were faulty (8 comments). Other negative comments commonly made were:

- ❖ *The accommodation was infested with bugs (7 comments)*
- ❖ *The accommodation was cold and in some cases mould was detected (6 comments)*
- ❖ *There was no or limited internet or phone reception was poor (6 comments)*
- ❖ *The accommodation was old or dated (6 comments)*
- ❖ *The Trainees had issues with administrative matters relating to their accommodation (5 comments)*
- ❖ *The accommodation was dirty (4 comments)*
- ❖ *There was evidence of asbestos (4 comments)*
- ❖ *The accommodation was not able to be secured sufficiently (4 comments)*
- ❖ *The accommodation was too small for requirements (3 comments)*
- ❖ *There were too many ongoing maintenance issues (3 comments)*
- ❖ *The kitchen, bathroom or furniture were unsatisfactory (2 comments each)*
- ❖ *No details of the accommodation were provided prior to arrival which made planning difficult (2 comments)*
- ❖ *The accommodation was shared with other employees (2 comments)*
- ❖ *The accommodation was too far away from the hospital (1 comment)*
- ❖ *The Trainee had to move out shortly after moving in (1 comment)*

Rotation setting

Public, private or mixed setting

Figure 4: Rotation setting – Public, private or mixed



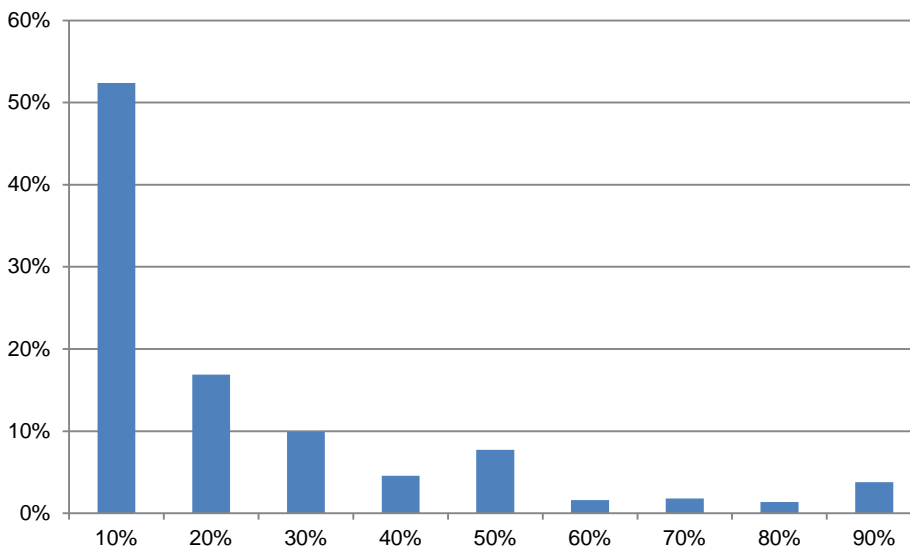
As seen in Figure 4, of the 2,188 respondents who answered this question, 80.8% of individuals completed their rotation in a public setting. A further 16.3% of respondents completed their rotation in a mixed setting.

Individuals who completed their rotation in a mixed setting were asked what percentage of their time was spent in a private setting. The results are displayed in Figure 5. The majority of respondents only spent 10% of their time in a private setting.

Percentage of Time Spent in private setting

Total number of all Trainees to answer this question: 504

Figure 5: Percentage of time in private setting



Team structure

Numbers of each grade of Doctor

Respondents were asked how many doctors of each grade were on their team. Responses are displayed in Tables 7-11.

Most specialties require a minimum number of Consultants on the unit per allocated Trainee; this is at least two but normally three.

Some Trainees responded that there were no trainees on their unit in Table 9. In these cases, it is assumed they were discounting themselves and referring to a second trainee. This option has been removed from future surveys.

Table 7: Number of Consultants

	Number of Respondents	0	1	2	3	4	5
All Specialties	2,169	0.2%	2.6%	13.7%	18.4%	18.0%	47.1%
Cardiothoracic Surgery	53	3.8%	1.9%	13.2%	9.4%	37.7%	34.0%
General Surgery	993		3.1%	17.1%	23.1%	21.2%	35.4%
Neurosurgery	108			0.9%	13.9%	27.8%	57.4%
Orthopaedic Surgery	346	0.3%	5.2%	19.4%	20.5%	9.0%	45.7%
OHNS	172			1.2%	8.1%	6.4%	84.3%
Paediatric Surgery	70		1.4%	20.0%	31.4%	17.1%	30.0%
Plastic Surgery	157			8.3%	7.6%	8.9%	75.2%
Urology	193	0.5%	3.1%	10.9%	10.4%	19.7%	55.4%
Vascular Surgery	77			3.9%	14.3%	29.9%	51.9%

Table 8: Number of fellows

	Number of Respondents	0	1	2	3	4	5
All Specialties	2,169	56.6%	31.7%	8.2%	2.1%	0.8%	0.7%
Cardiothoracic Surgery	53	30.2%	43.4%	9.4%	3.8%	1.9%	11.3%
General Surgery	993	59.0%	31.7%	6.8%	1.6%	0.5%	0.3%
Neurosurgery	108	63.9%	23.1%	10.2%	0.9%	1.9%	
Orthopaedic Surgery	346	56.6%	25.1%	7.8%	6.1%	2.3%	2.0%
OHNS	172	45.3%	36.6%	16.9%	1.2%		
Paediatric Surgery	70	62.9%	31.4%	4.3%		1.4%	
Plastic Surgery	157	50.3%	38.2%	10.8%	0.6%		
Urology	193	62.2%	31.6%	5.2%	1.0%		
Vascular Surgery	77	50.6%	40.3%	9.1%			

Table 9: Number of SET Trainees

	Number of Respondents	0	1	2	3	4	5
All Specialties	2,169	3.0%	54.1%	30.7%	8.7%	2.1%	1.5%
Cardiothoracic Surgery	53	1.9%	75.5%	22.6%			
General Surgery	993	2.8%	63.8%	25.3%	5.9%	1.3%	0.8%
Neurosurgery	108		31.5%	61.1%	7.4%		
Orthopaedic Surgery	346	4.0%	58.7%	14.2%	14.5%	6.4%	2.3%
OHNS	172	1.2%	34.3%	48.3%	12.2%		4.1%
Paediatric Surgery	70	4.3%	32.9%	42.9%	14.3%	1.4%	4.3%
Plastic Surgery	157	4.5%	36.3%	40.8%	14.6%	1.9%	1.9%
Urology	193	4.7%	48.2%	38.9%	5.7%	1.6%	1.0%
Vascular Surgery	77		40.3%	45.5%	7.8%	5.2%	1.3%

Table 10: Number of PGY3+

	Number of Respondents	0	1	2	3	4	5
All Specialties	2,169	56.0%	34.0%	5.1%	1.9%	1.7%	1.2%
Cardiothoracic Surgery	53	13.2%	32.1%	34.0%	15.1%	5.7%	
General Surgery	993	56.0%	34.0%	5.1%	1.9%	1.7%	1.2%
Neurosurgery	108	13.0%	32.4%	38.0%	9.3%	4.6%	2.8%
Orthopaedic Surgery	346	34.1%	35.8%	17.3%	4.6%	2.9%	5.2%
OHNS	172	40.1%	52.3%	4.1%	2.3%	0.6%	0.6%
Paediatric Surgery	70	50.0%	34.3%	7.1%	4.3%	1.4%	2.9%
Plastic Surgery	157	19.7%	49.7%	18.5%	8.3%	2.5%	1.3%
Urology	193	51.8%	34.7%	6.7%	2.6%	2.6%	1.6%
Vascular Surgery	77	51.9%	29.9%	18.2%			

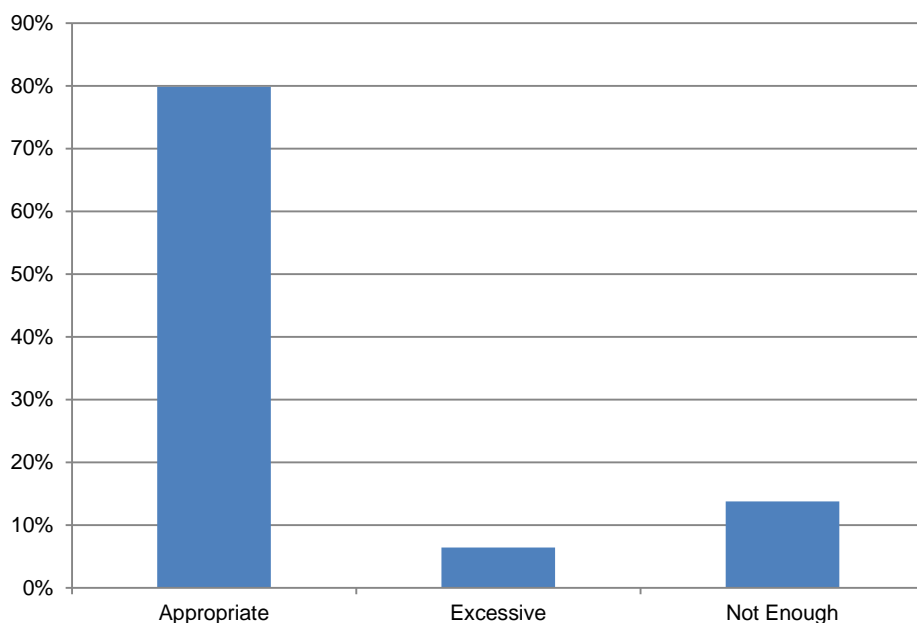
Table 11: Number of PGY 1/2

	Number of Respondents	0	1	2	3	4	5
All Specialties	2,169	12.3%	39.4%	29.6%	9.3%	5.2%	4.2%
Cardiothoracic Surgery	53	3.8%	26.4%	43.4%	22.6%		3.8%
General Surgery	993	12.9%	35.3%	33.2%	10.0%	5.0%	3.5%
Neurosurgery	108	8.3%	20.4%	39.8%	14.8%	8.3%	8.3%
Orthopaedic Surgery	346	9.5%	46.2%	22.3%	5.8%	6.6%	9.5%
OHNS	172	15.7%	51.2%	22.1%	8.1%	2.9%	
Paediatric Surgery	70	14.3%	57.1%	18.6%	4.3%	4.3%	1.4%
Plastic Surgery	157	10.2%	43.9%	26.1%	9.6%	6.4%	3.8%
Urology	193	17.6%	46.6%	23.3%	6.7%	4.1%	1.6%
Vascular Surgery	77	9.1%	27.3%	40.3%	13.0%	6.5%	3.9%

Do you feel that there were enough junior doctors in your unit to staff your roster?

2,012 respondents answered whether they felt there were enough junior doctors in their unit to staff their rotation. Results in Figure 6 indicated that nearly 80% of respondents indicated that there were an appropriate number of junior doctors on their rotation.

Figure 6: Do you feel there were enough junior doctors in your unit to staff your roster?



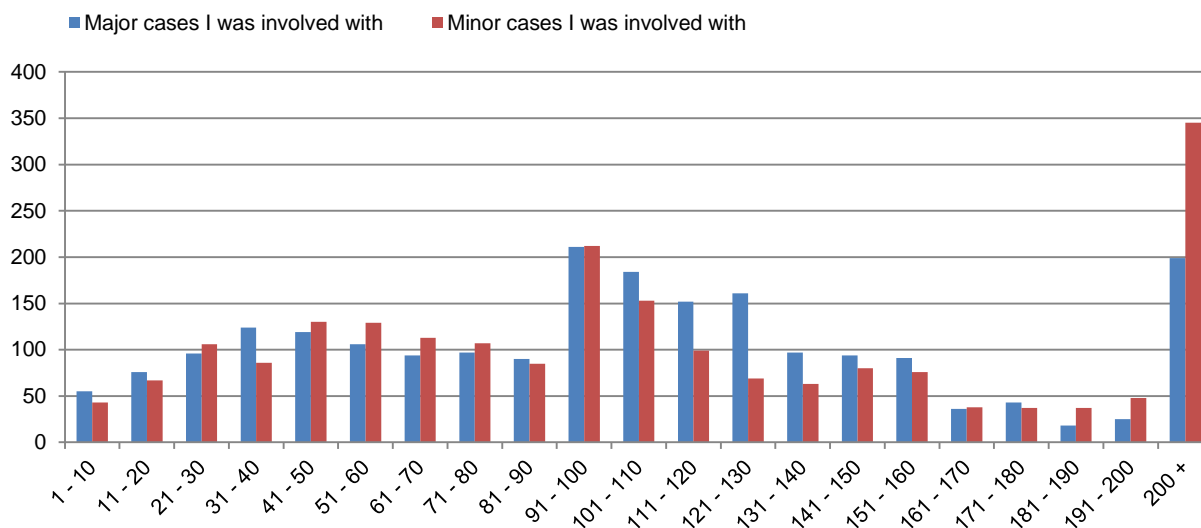
Workload

Number of cases

Figure 7 displays the number of major and minor cases the respondents were involved in.

Total number of respondents: 2,168 for major cases
2,123 for minor cases

Figure 7: Number of major and minor cases I was involved with

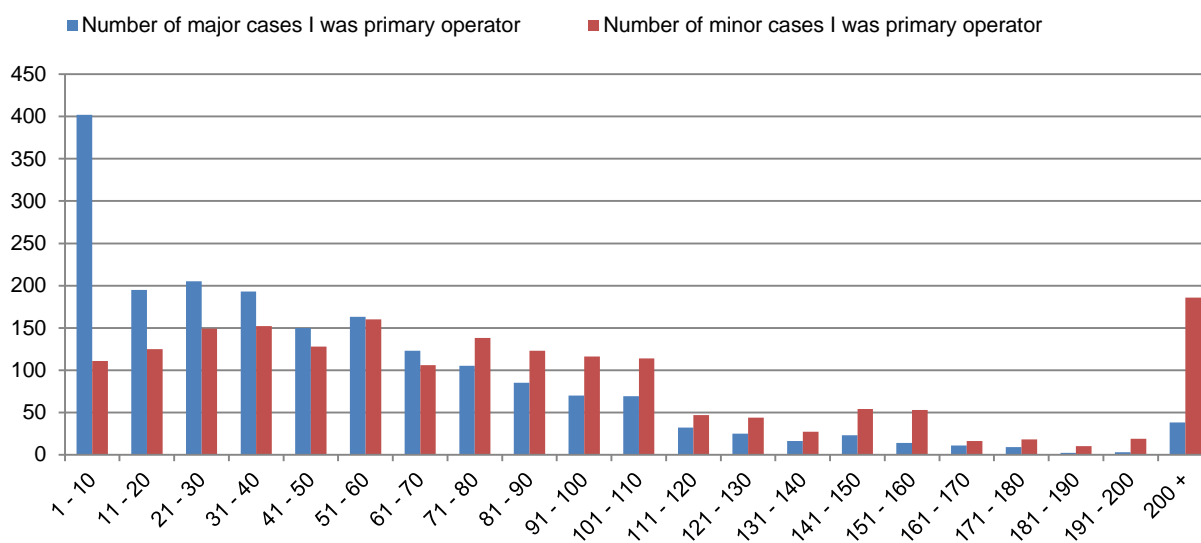


Primary operator

Figure 8 displays the number of major and minor cases for which respondents were the primary operator during their rotation.

Total number of respondents: 1,933 for major cases
1,896 for minor cases

Figure 8: Number of major and minor cases when I was primary operator



How often would you record yourself as the Primary Operator when you performed a part of the operation and not the majority?

Total number of all Trainees to answer this question: 2,012

Figure 9: How often would you record yourself as Primary Operator when you performed a part of the operation but not the majority?

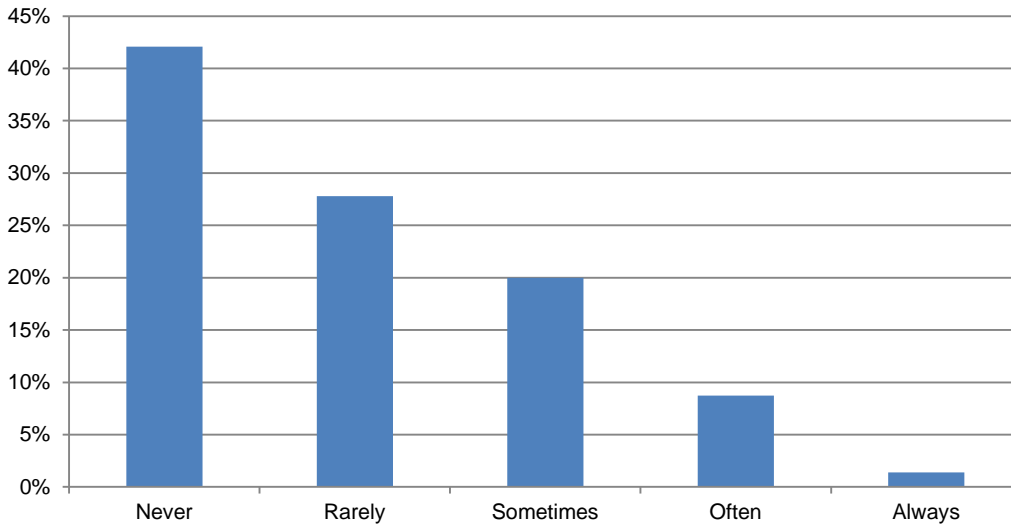


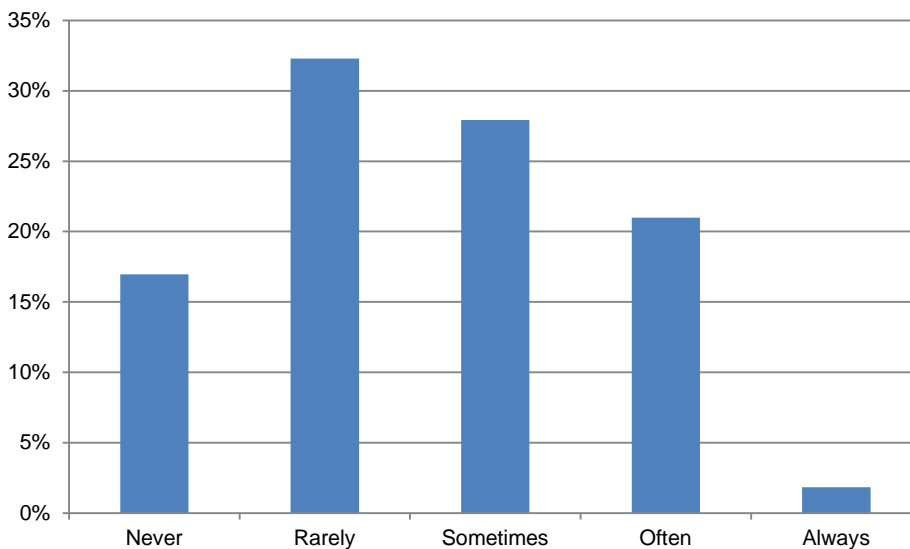
Figure 9 shows that nearly 70% never or rarely record themselves as primary operator when they only perform some part of the operation.

How often were you second assistant?

Total number of Trainees to answer this question: 2,016

Nearly 50% of trainees who responded were never or rarely the second assistant as seen in Figure 10.

Figure 10: How often were you second assistant



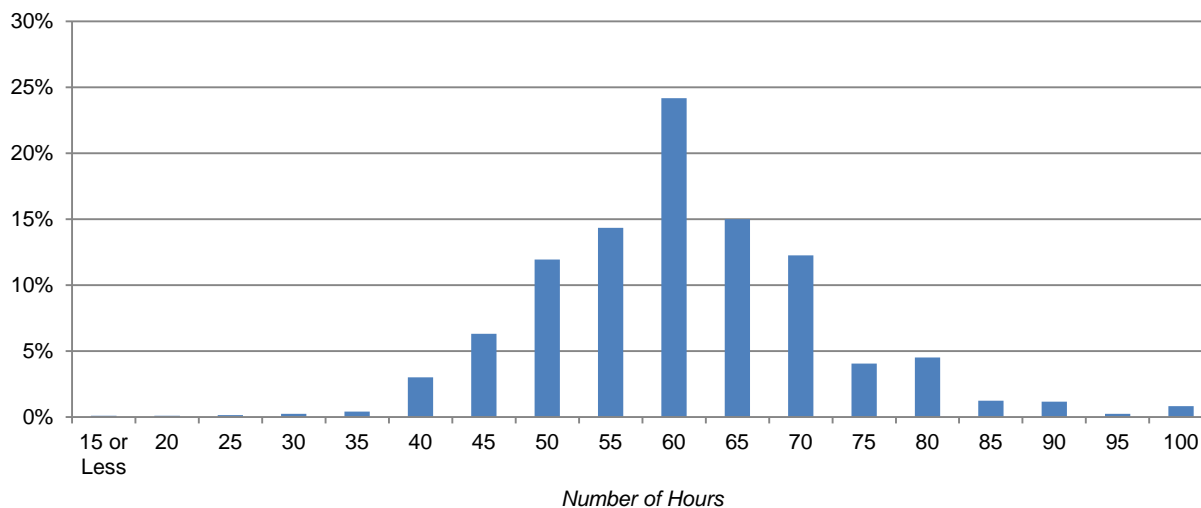
Hours at work

Hours spent at work per week

When asked how many hours they spent at work each week, respondents most frequently reported that they were at work 60 hours per week. This figure excluded any off-site on-call hours. See Figure 11.

Total number of all Trainees to answer this question: 2,169

Figure 11: Hours at work per week

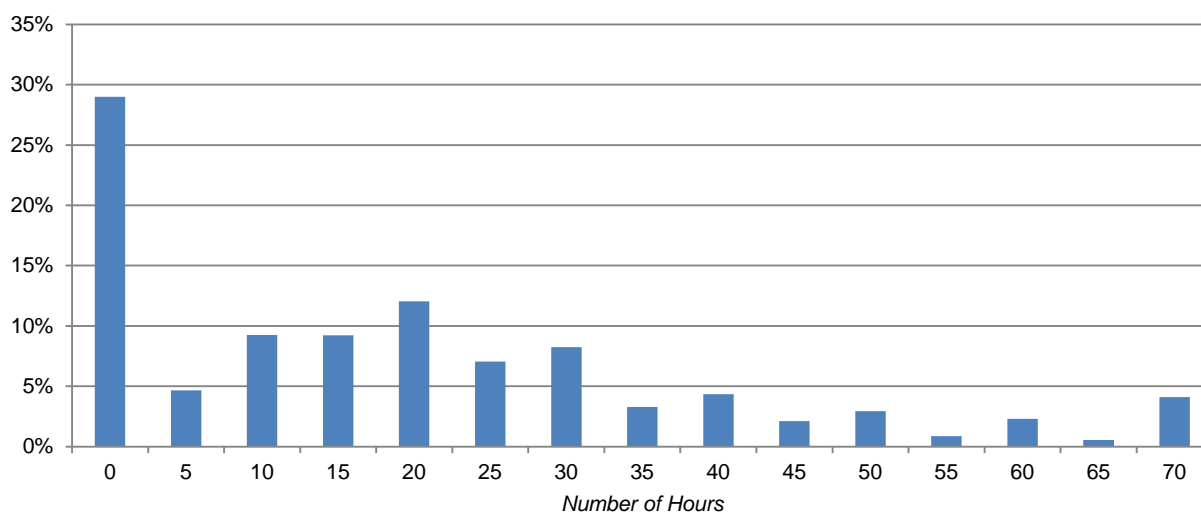


Off-site on-call hours per week

Total number of all Trainees to answer this question: 2,169

As seen in Figure 12, respondents most frequently reported that they did not participate in off-site on call hours.

Figure 12: Off-site on-call hours per week



Did you do 24-hour on call?

As seen in Table 12, the majority of candidates indicated that they did 24-hour on call with significant variation between specialties.

Table 12: 24-hour on call

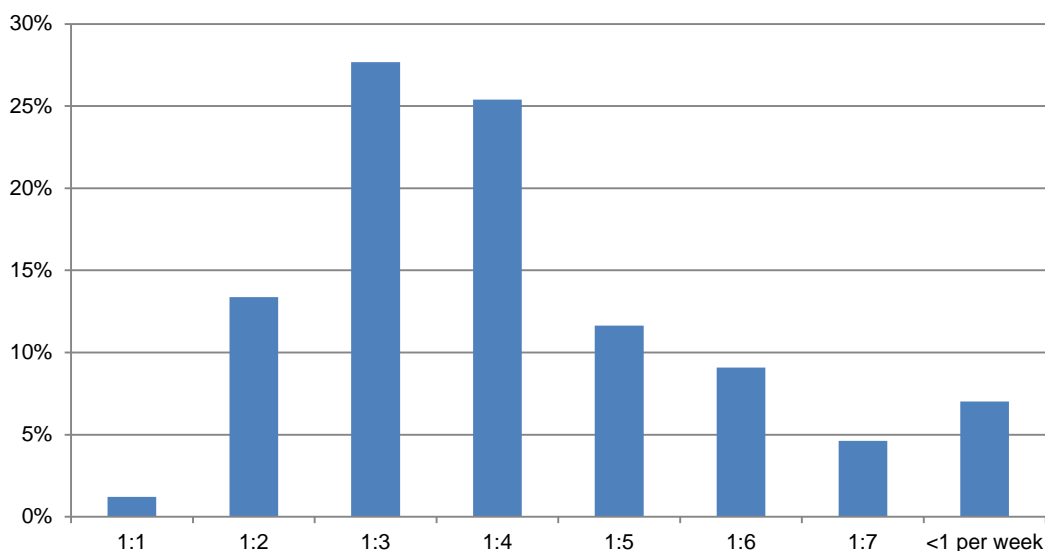
	Number of Respondents	Yes	No
All Specialties	2,169	68.6%	31.4%
Cardiothoracic Surgery	53	92.5%	7.5%
General Surgery	993	47.7%	52.3%
Neurosurgery	108	95.4%	4.6%
Orthopaedic Surgery	346	84.4%	15.6%
OHNS	172	86.6%	13.4%
Paediatric Surgery	70	72.9%	27.1%
Plastic Surgery	157	92.4%	7.6%
Urology	193	81.9%	18.1%
Vascular Surgery	77	88.3%	11.7%

Frequency of 24-hour call

Total number of all Trainees to answer this question: 1,496

Individuals who responded yes to participating in 24-hour call, were asked how frequently they did so. Responses can be seen in Figure 13.

Figure 13: Frequency of 24-hour call

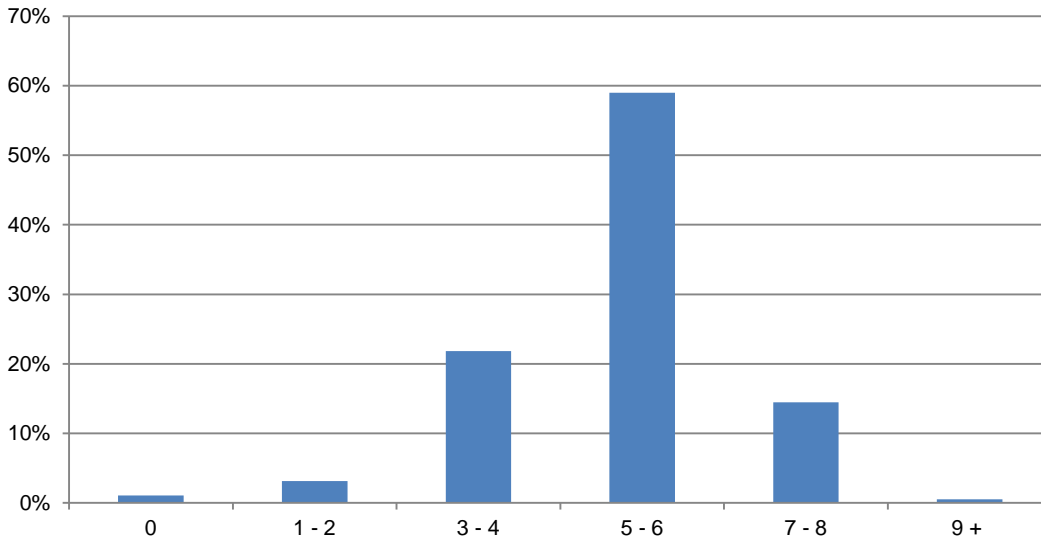


Average total hours slept overnight

Total number of Trainees to answer this question: 1,501

Figures 14 and 15 show the responses for how much sleep respondents had while rostered for overnight on-call. The majority of respondents managed 5-6 hours sleep of which 3-4 hours was uninterrupted.

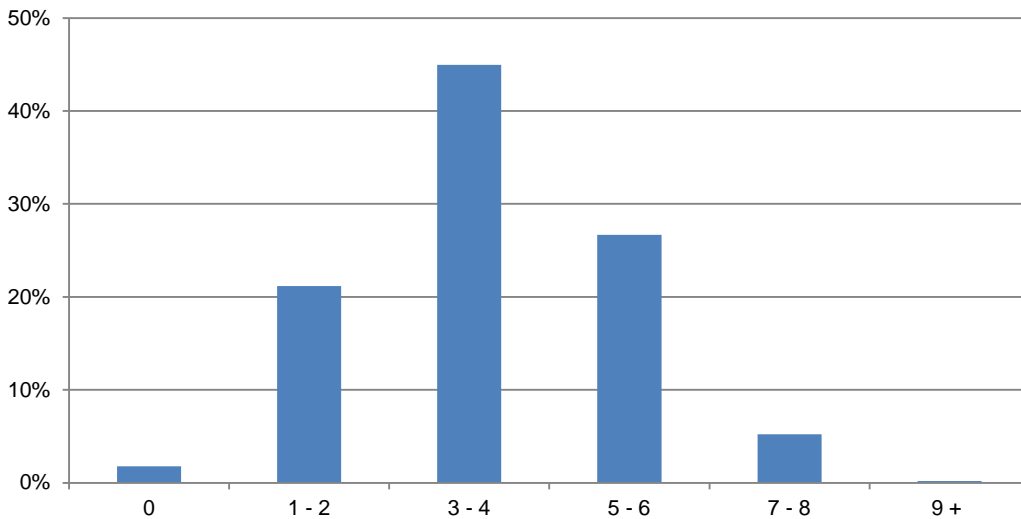
Figure 14: Average hours of sleep overnight



Average period of uninterrupted sleep overnight

Total number of Trainees to answer this question: 1,470

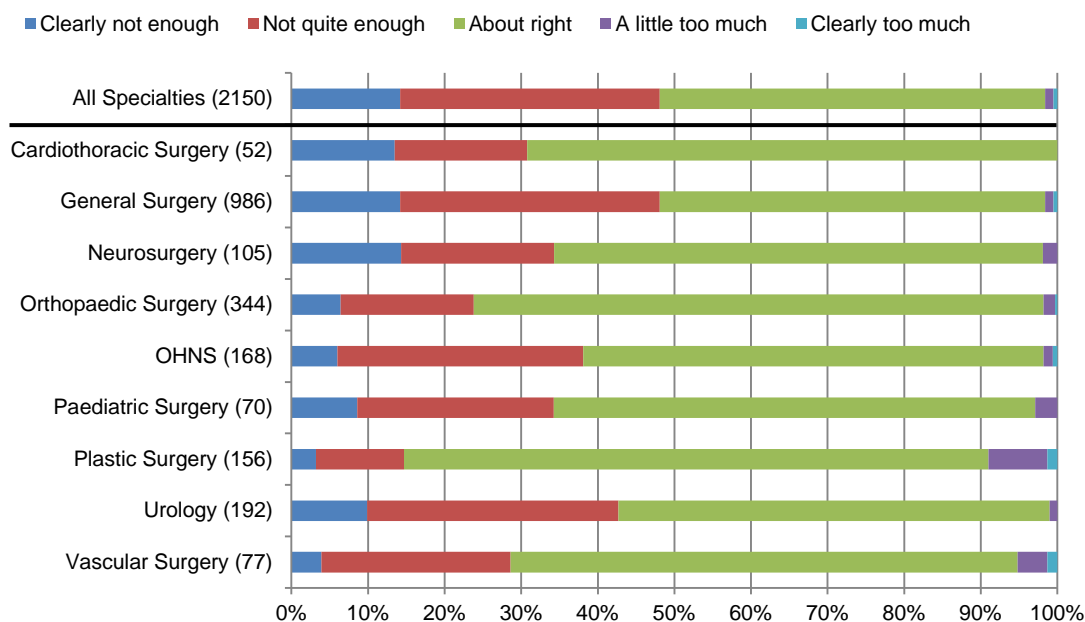
Figure 15: Average period of uninterrupted sleep overnight



Acute operating exposure and support

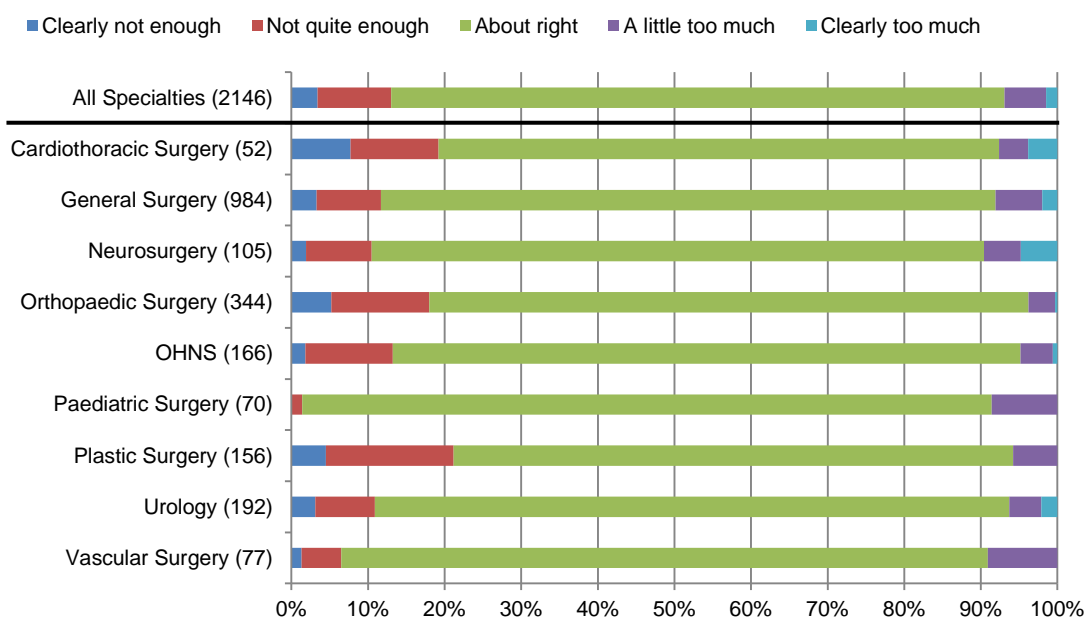
Respondents were asked to rate their experience of acute operating from “clearly not enough” to “clearly too much”. The responses are shown in Figure 16. Most respondents believed that their exposure was “about right”.

Figure 16: Acute operating exposure



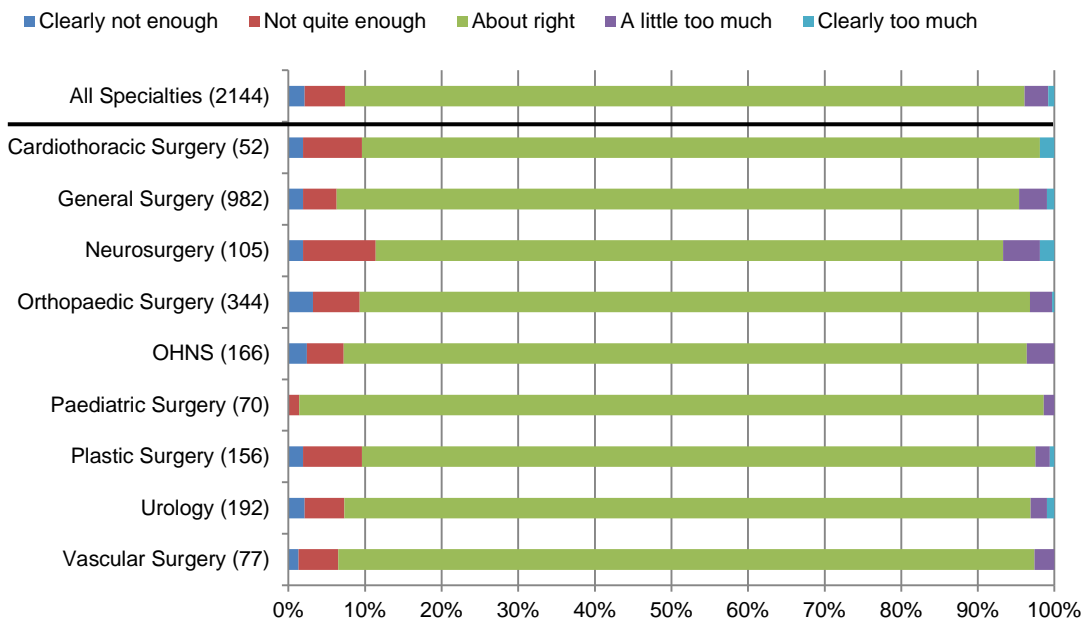
Respondents were asked to rate the support from Consultants for acute operating from “clearly not enough” to “clearly too much”. The responses are shown in Figure 17. Most respondents believe that their exposure and level of support was “about right”.

Figure 17: Acute operating support from Consultants



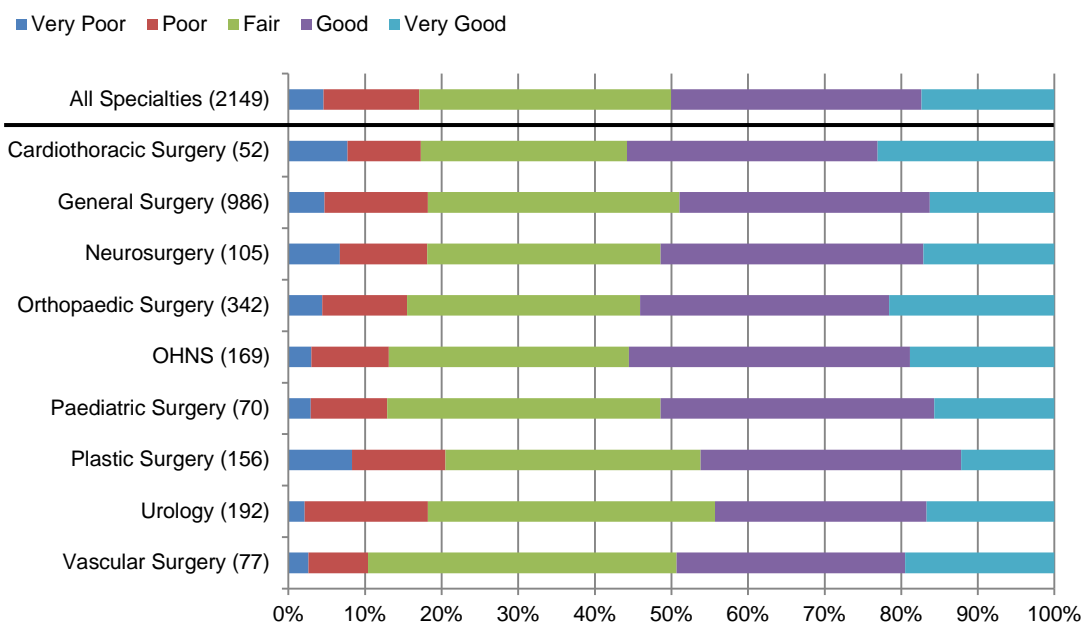
Respondents were asked to rate the support from Consultants for acute decision making from “clearly not enough” to “clearly too much”. The responses are shown in Figure 18. Most respondents believe that their exposure and level of support was “about right”.

Figure 18: Support provided for my acute decision making



Respondents were asked to rate how well their training was incorporated into their acute work. The responses are shown below in Figure 19. 50% of respondents answered that it was good or very good; less than 20% rated it as poor or very poor. The remaining cohort (approx. 30%) rated the training in this area of their work as fair.

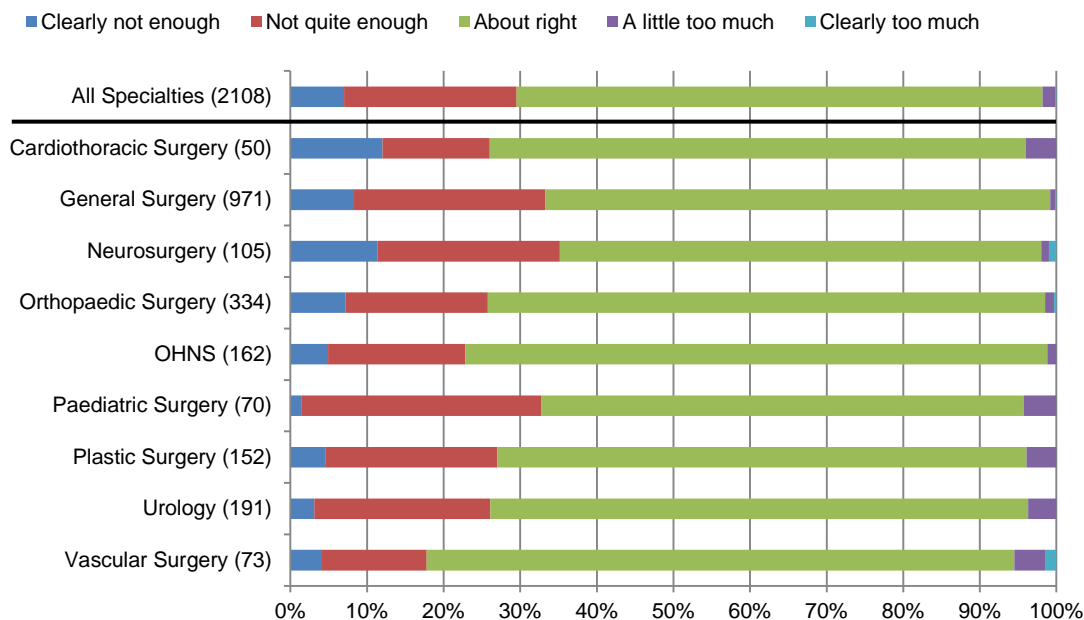
Figure 19: Quality of training for acute work



Elective theatre and wards

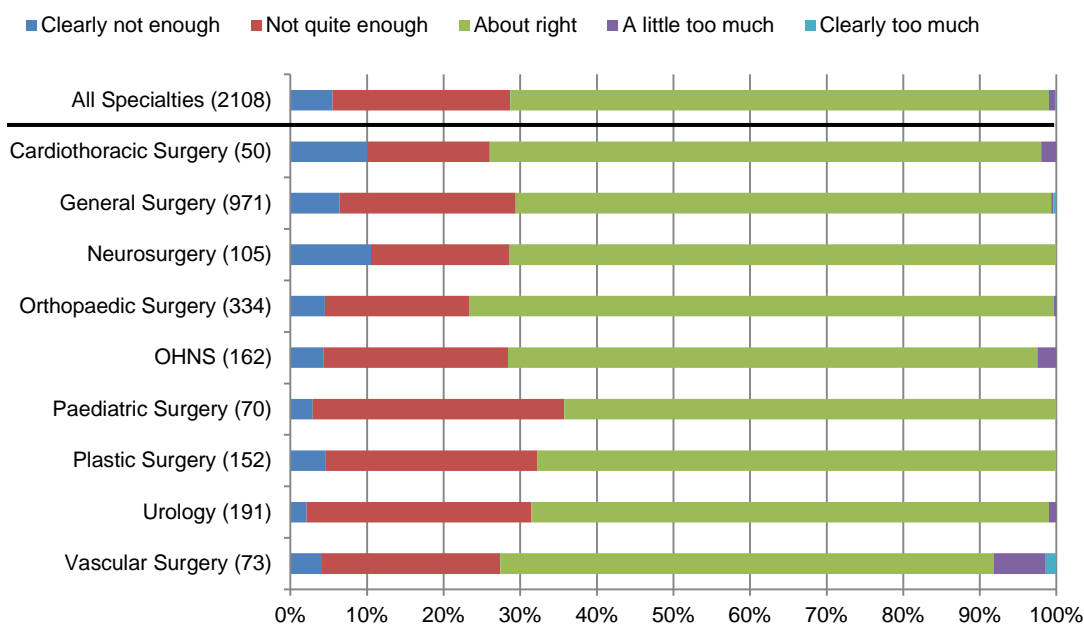
Respondents were asked about their level of responsibility in elective theatre. The results can be seen in Figure 20. The greater proportion of responses indicates that respondents felt the responsibility they had was about right.

Figure 20: Level of responsibility I was given in elective theatre



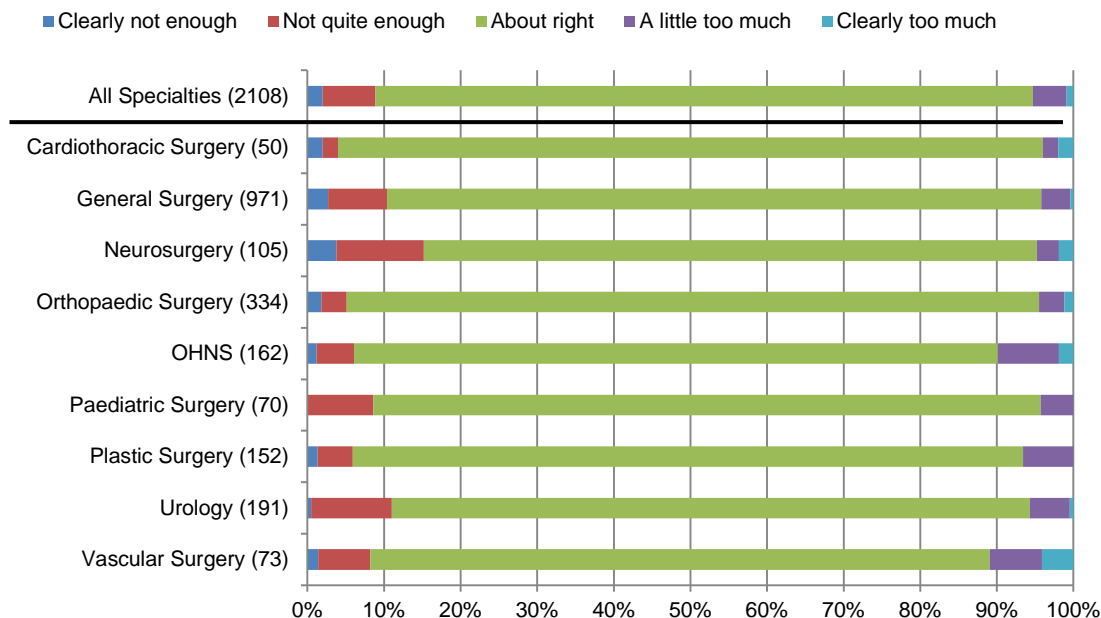
Respondents were asked about their learning opportunities in Elective theatre. The results can be seen in Figure 21. Approximately 70% of respondents felt that the learning opportunities were about right.

Figure 21: Learning opportunities in elective theatre



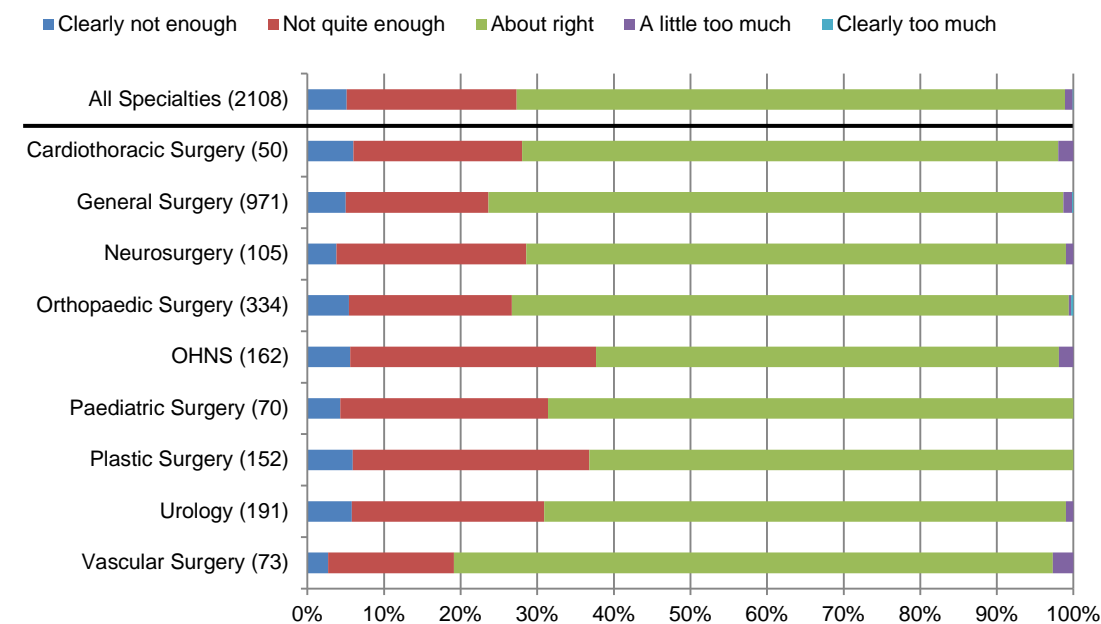
Respondents were asked about their level of responsibility on elective surgery wards. The results can be seen in Figure 22. Over 85% of respondents felt that the level of responsibility was about right.

Figure 22: Level of responsibility I was given on the wards



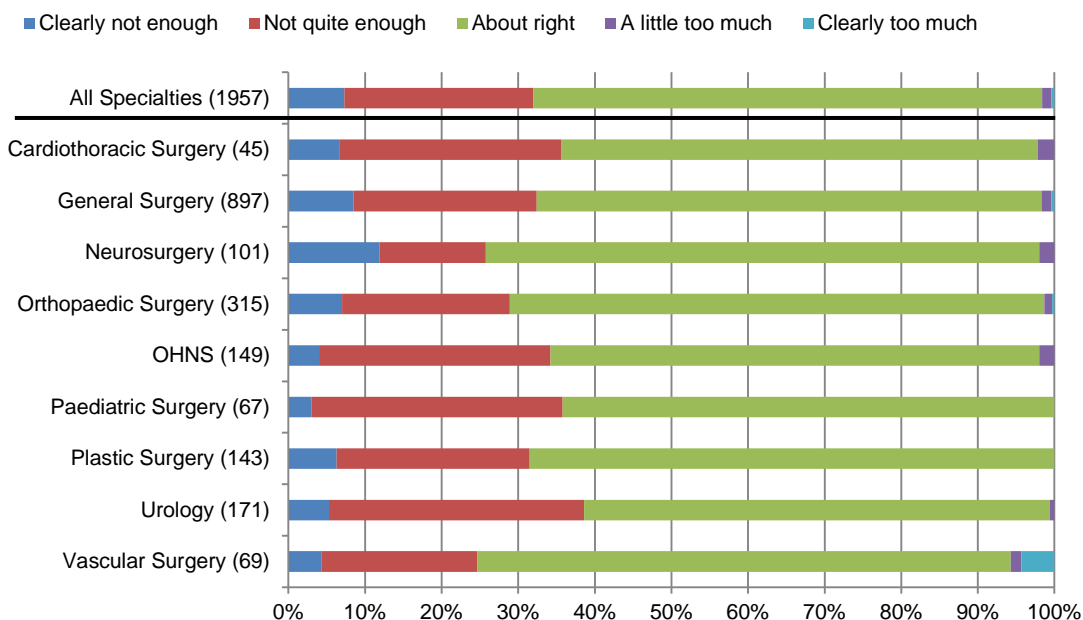
Respondents were asked about their learning opportunities in elective surgery wards. The results can be seen in Figure 23. On average, 70% of respondents felt that the learning opportunities available in elective surgery wards were about right, in contrast with 85% who thought the level of responsibility was about right on elective wards.

Figure 23: Learning opportunities on the wards



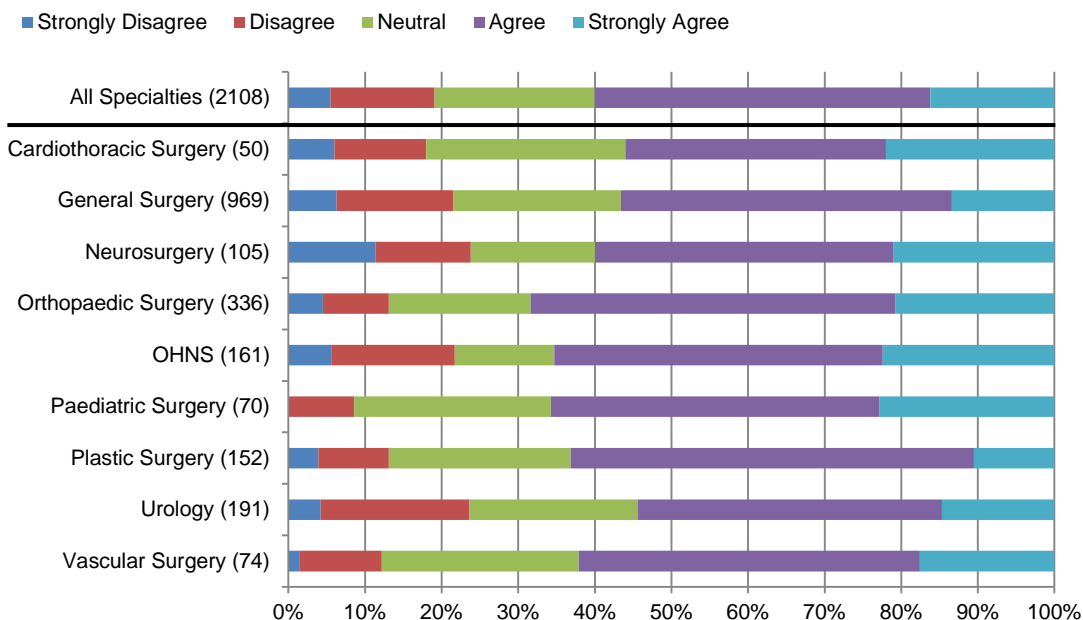
Respondents were asked about their exposure in elective operating. The results can be seen in Figure 24. A third of respondents thought there wasn't enough exposure.

Figure 24: Elective operating exposure



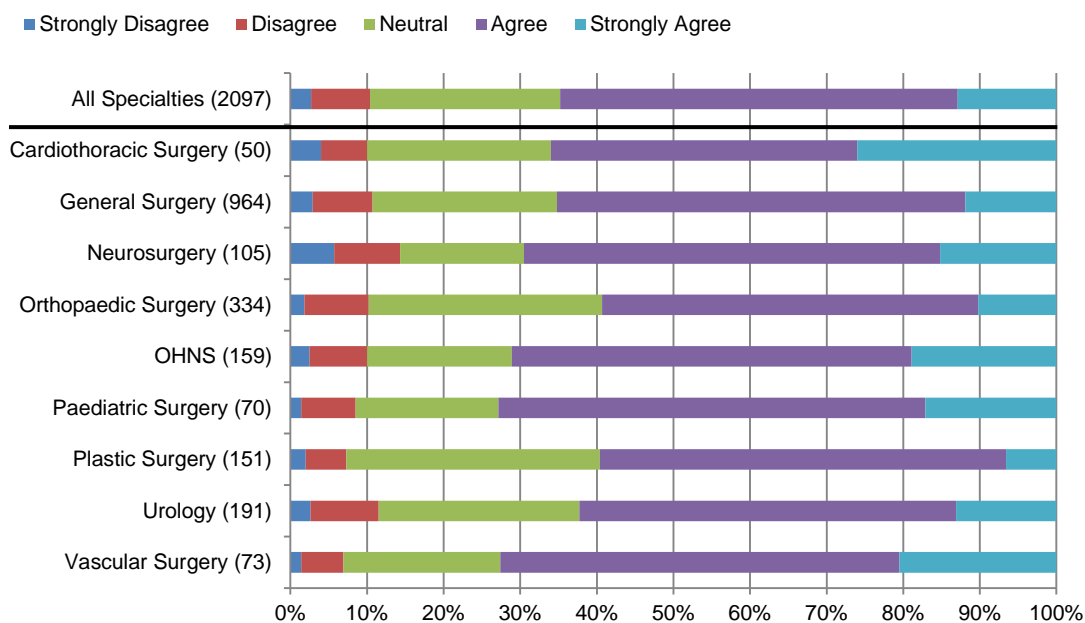
As seen in Figure 25, respondents were asked about the appropriateness of the operative lists for their training needs. Nearly 20% did not think the lists met their training needs, and a further 20% provided a neutral answer.

Figure 25: Operating Lists were appropriate for my training needs



As seen in Figure 26, respondents were asked about the appropriateness of ward work for their training needs. About 65% agreed that work required on the wards was useful for their training. 10% disagreed that time spent on the ward was useful for training with the remaining responses being neutral.

Figure 26: Ward work was appropriate for my training needs



Outpatient Clinics

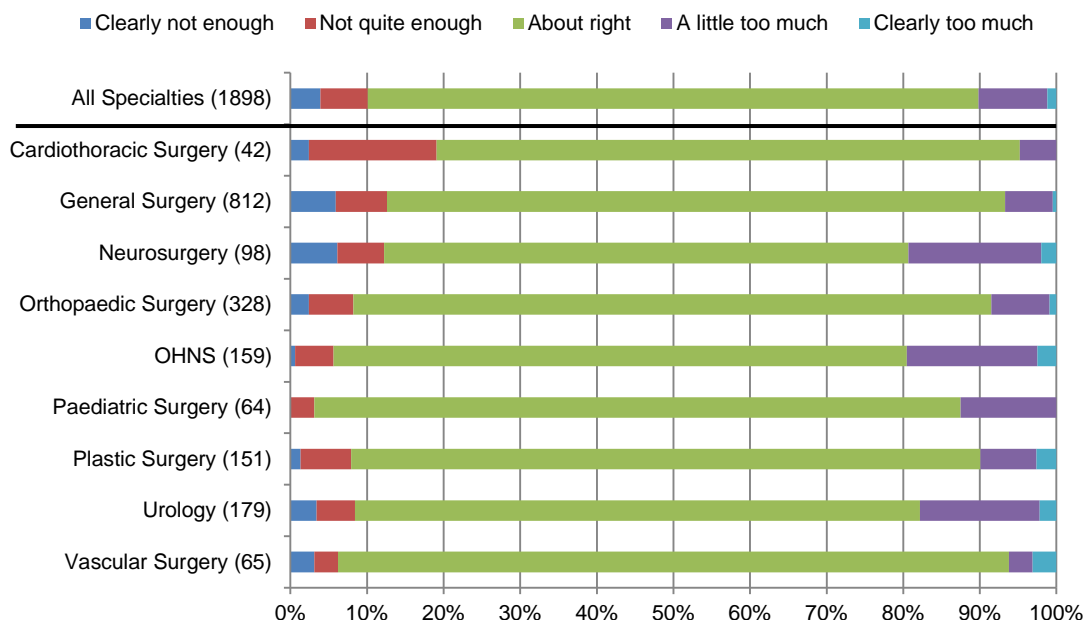
Respondents were asked if they attended outpatient clinics. The results can be seen in Table 13. It is a requirement of post accreditation that all trainees have education and training in supervised outpatient clinic.

Table 13: Outpatient Clinic Attendance

	Number of Respondents	Yes	No
All Specialties	2,109	86.8%	13.2%
Cardiothoracic Surgery	50	72.0%	28.0%
General Surgery	970	79.1%	20.9%
Neurosurgery	105	86.7%	13.3%
Orthopaedic Surgery	336	96.7%	3.3%
OHNS	161	100.0%	
Paediatric Surgery	70	91.4%	8.6%
Plastic Surgery	152	99.3%	0.7%
Urology	191	90.6%	9.4%
Vascular Surgery	74	83.8%	16.2%

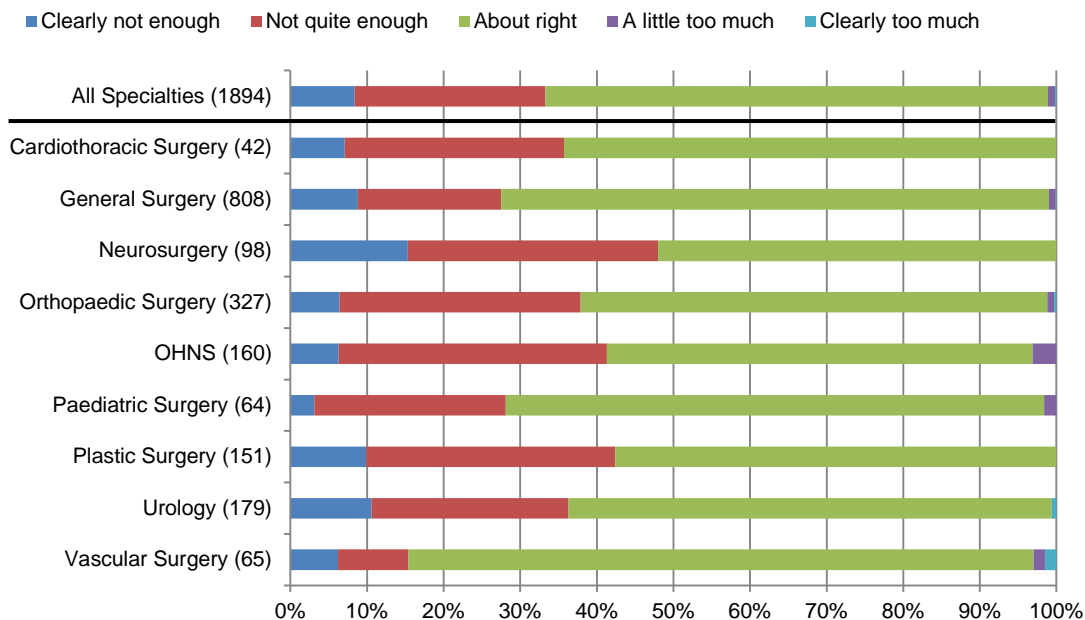
Respondents were asked about the level of responsibility they had in outpatient clinics. The results can be seen in Figure 27. Nearly 80% thought it was about right with smaller numbers in each other rating.

Figure 27: Level of responsibility I was given in outpatients



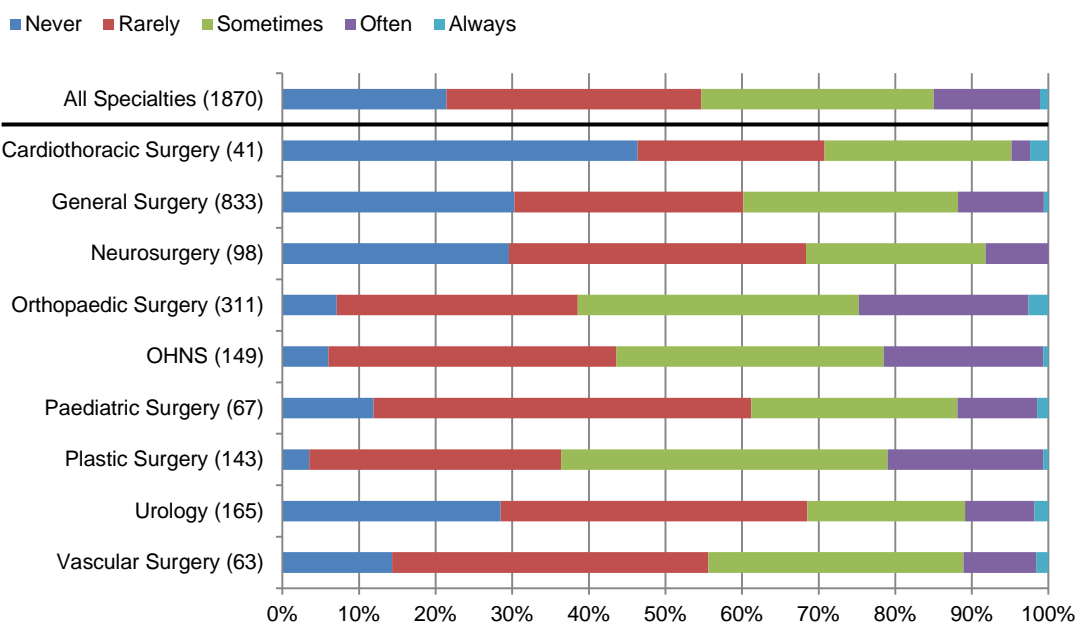
Respondents were asked about the learning opportunities they had in outpatient clinics. The results can be seen in Figure 28. 30% of respondents thought there were not enough learning opportunities.

Figure 28: Learning opportunities in outpatients



Respondents were asked how often their boss would take them through an examination or case in Outpatients for teaching purposes. As can be seen in Figure 29, more than 50% of respondents rarely or never received teaching in Outpatients.

Figure 29: How often would your boss take you through an examination or case in outpatients for teaching purposes?



Respondents were asked to estimate the number of patients seen in Outpatient clinics in each session. Tables 14 and 15 depict the number of all patients and new patients seen. There is great variation in the data between specialties, with nearly 50% of trainees in Orthopaedics and Plastic and Reconstructive Surgery seeing more than 40 patients per clinic. Over 70% of Cardiothoracic respondents saw fewer than 5 patients in each clinic. In general, this reflects the volume of patients that attend clinic.

All patients

Table 14: Outpatient clinic - All patients

	Number of Respondents	0-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	41+
All Specialties	1,784	10.9%	14.3%	15.1%	13.9%	8.9%	9.7%	5.7%	4.6%	16.9%
Cardiothoracic	39	71.8%	17.9%	10.3%						
General	769	15.1%	21.1%	19.0%	18.6%	9.4%	7.7%	4.0%	2.2%	3.0%
Neurosurgery	95	12.6%	17.9%	31.6%	18.9%	7.4%	8.4%	1.1%	2.1%	
Orthopaedic	308	3.2%	6.2%	4.9%	6.2%	5.5%	11.0%	7.5%	8.8%	46.8%
OHNS	148		2.0%	4.7%	7.4%	9.5%	18.2%	13.5%	13.5%	31.1%
Paediatric	60	6.7%	8.3%	20.0%	21.7%	25.0%	8.3%	5.0%		5.0%
Plastic	143	3.5%	2.1%	5.6%	4.9%	6.3%	16.8%	7.0%	5.6%	48.3%
Urology	162	8.6%	14.2%	19.8%	13.6%	14.8%	7.4%	8.0%	4.9%	8.6%
Vascular	60	8.3%	28.3%	25.0%	25.0%	1.7%	6.7%	1.7%		3.3%

New patients

Table 15: Outpatient clinic - New patients

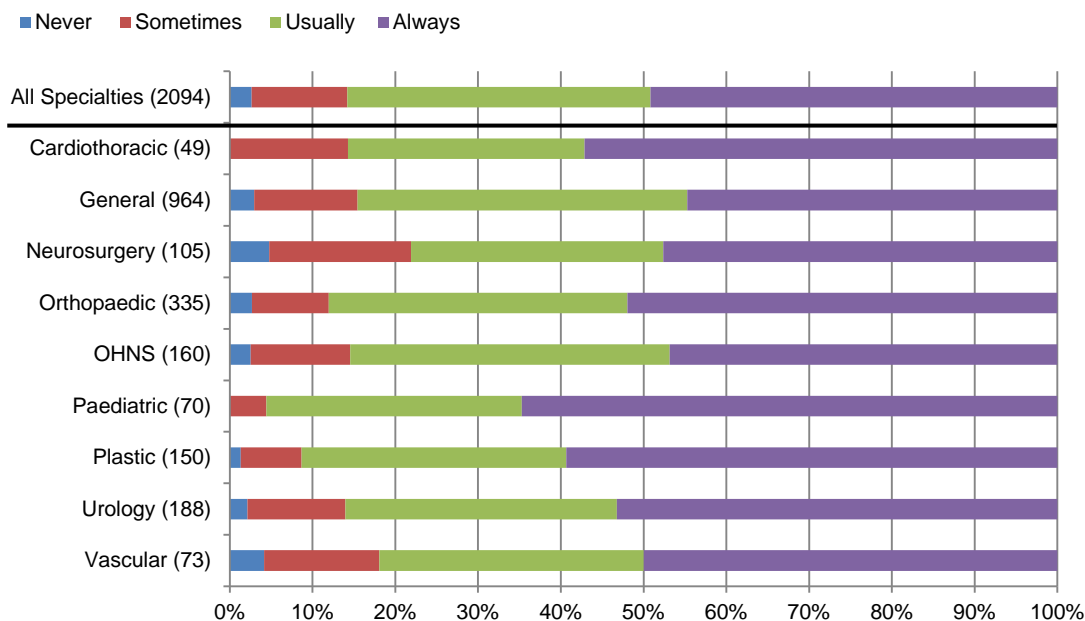
	Number of Respondents	0-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	41+
All Specialties	1,732	46.8%	31.4%	12.5%	5.1%	1.7%	1.0%	0.3%	0.2%	1.0%
Cardiothoracic	39	94.9%	2.6%				2.6%			
General	737	61.9%	28.5%	6.9%	2.0%	0.4%	0.1%			0.1%
Neurosurgery	91	60.4%	28.6%	9.9%		1.1%				
Orthopaedic	303	29.7%	35.0%	18.8%	6.6%	3.6%	2.0%	0.7%	1.0%	2.6%
OHNS	146	9.6%	32.9%	31.5%	17.1%	3.4%	3.4%	1.4%		0.7%
Paediatric	59	35.6%	49.2%	13.6%	1.7%					
Plastic	140	28.6%	32.1%	13.6%	12.1%	5.0%	2.1%	0.7%		5.7%
Urology	159	41.5%	35.2%	15.1%	6.3%	1.3%	0.6%			
Vascular	58	53.4%	39.7%	5.2%	1.7%					

Workplace experiences

Respondents were asked to comment on whether any leave requests were treated fairly. As can be seen in Figure 30, more than 80% of respondents believed their requests were usually or always treated fairly.

Figure 30: Were leave requests treated fairly?

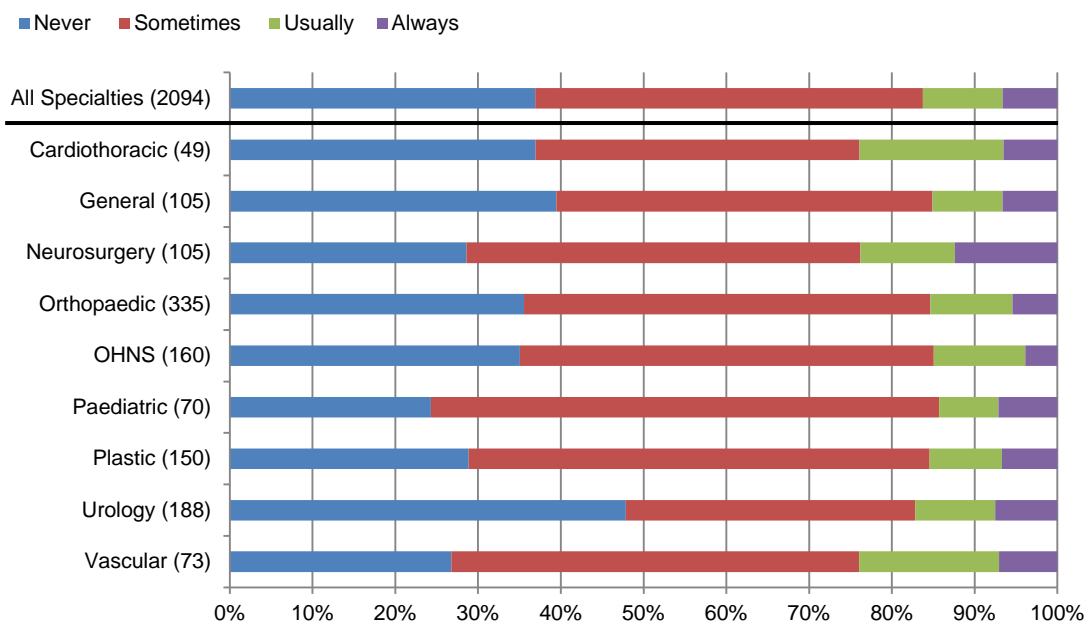
(This graph does not depict N/A responses)



Respondents were asked if the acute roster compromised their training opportunities at any time. The majority of respondents answered that training was sometimes compromised and just over a third on average saying the acute roster never compromised their training.

Figure 31: Did your acute roster compromise your training opportunities?

(This graph does not depict N/A responses)



Respondents were asked if their roster had frequent gaps. Nearly half of respondents did not have gaps and about 30% sometimes experienced this. These results can be seen in Figure 32.

Figure 32: Did your roster have frequent gaps?

(This graph does not depict N/A responses)

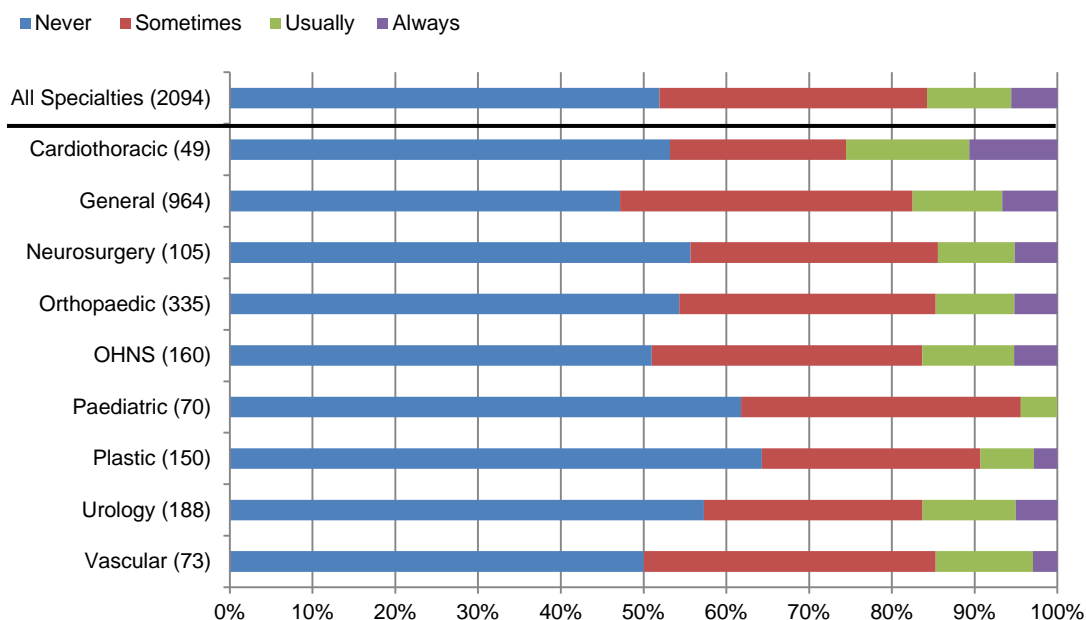


Figure 33 shows the respondents answers to whether formal teaching sessions were routinely provided. Just under 14% of the respondents indicated that they never had formal teaching sessions. The majority usually or always had sessions to attend.

Figure 33: Were formal teaching sessions routinely provided?

(This graph does not depict N/A responses)

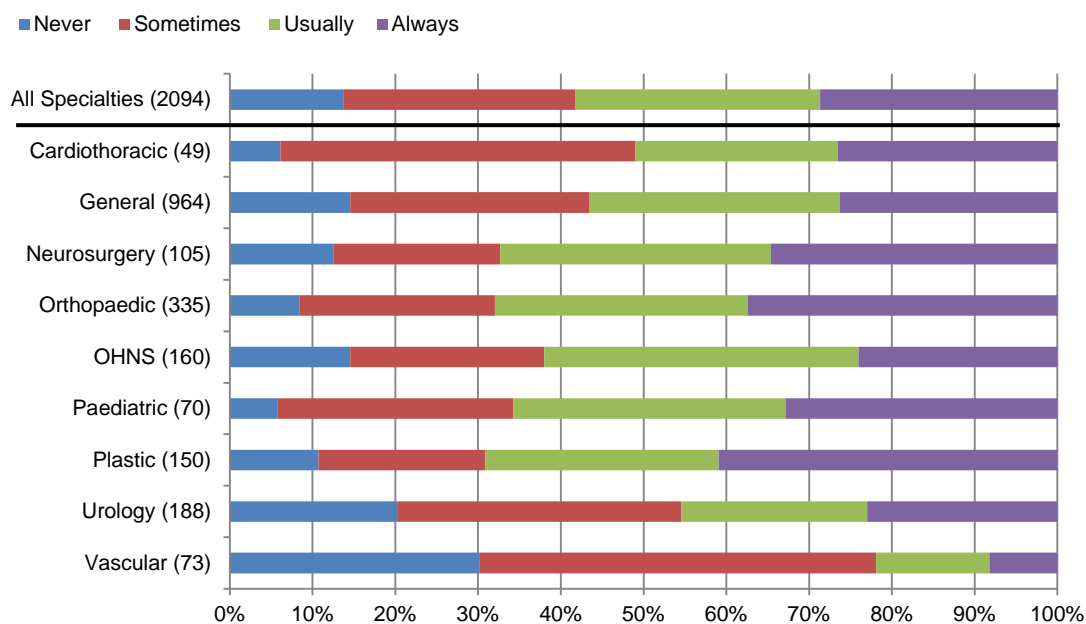
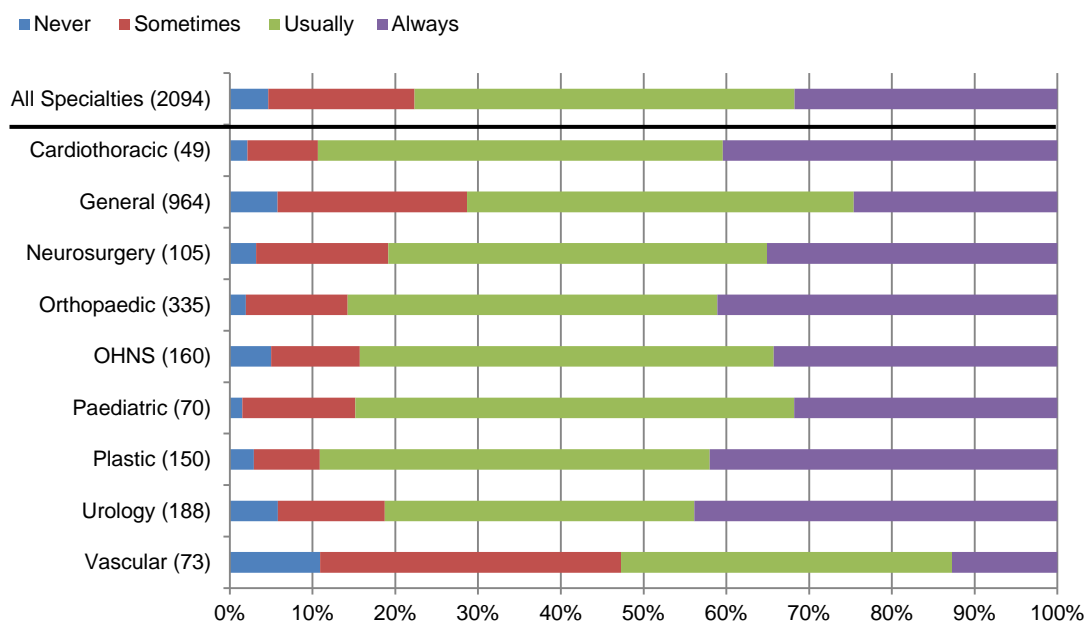


Figure 34 shows the results from respondents on whether they were able to attend the formal teaching sessions when offered. While nearly 70% of respondents could usually or always attend, 20% could only attend sometimes or not at all. Many specialties have set a minimum level of attendance for formal teaching sessions.

Figure 34: Were you able to attend formal teaching sessions?

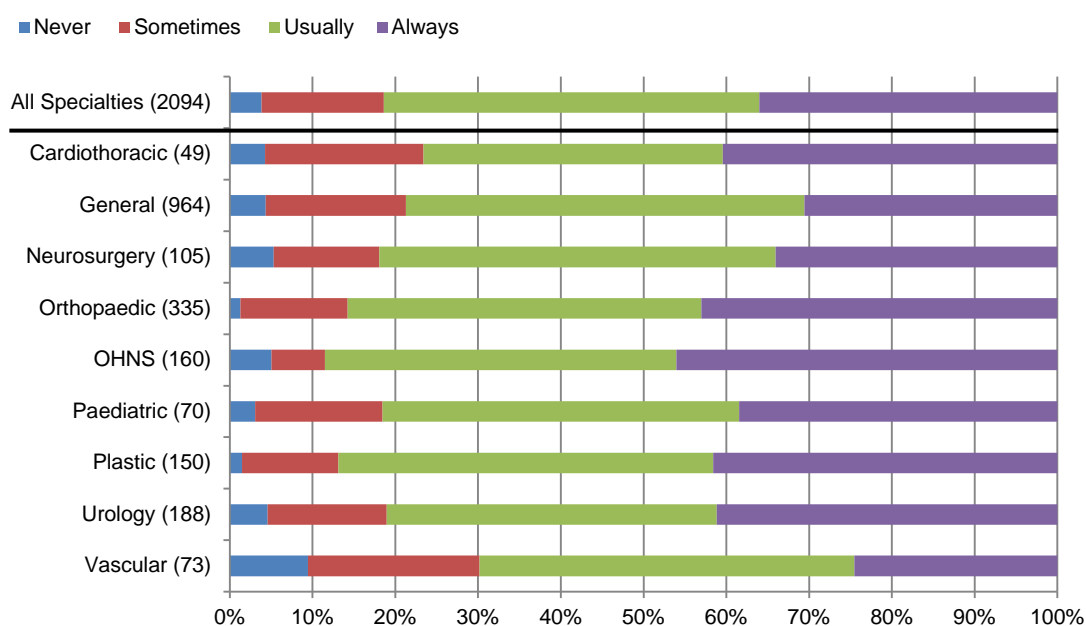
(This graph does not depict N/A responses)



Respondents were asked to rate whether the formal education sessions they attended were worthwhile. On average across all specialties, just over 70% usually or always found them worthwhile. The results can be seen in Figure 35.

Figure 35: Were the formal training sessions worthwhile?

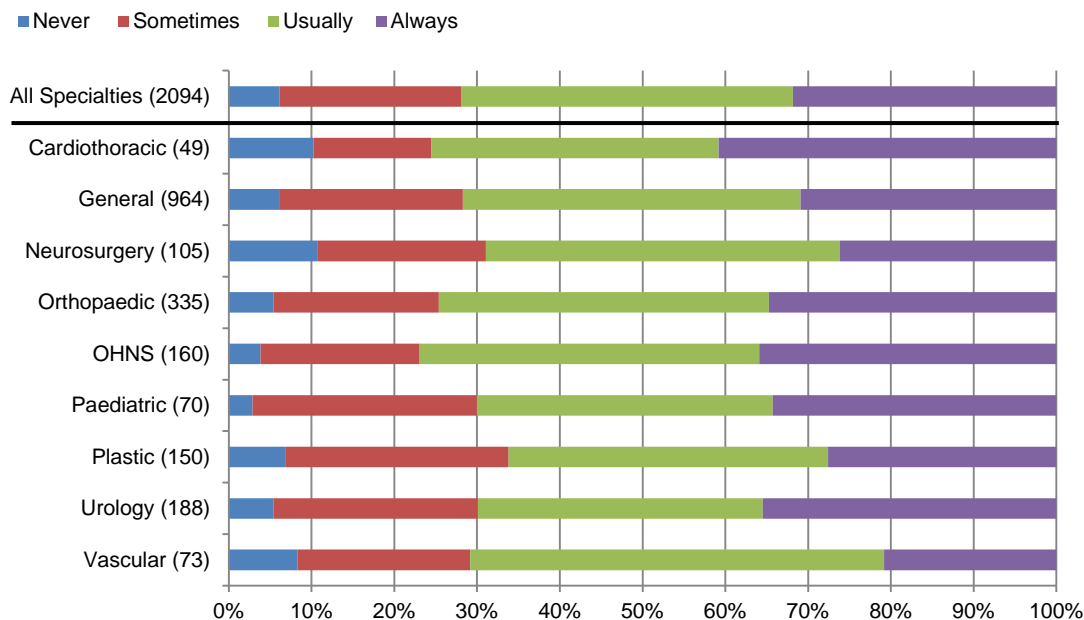
(This graph does not depict N/A responses)



Respondents were asked to rate whether teaching of medical and other health care professionals was encouraged while they were in that rotation. Only a minority said that it was never encouraged, with the majority feeling encouraged to teach. The results can be seen in Figure 36.

Figure 36: Was teaching medical and other health care professionals encouraged?

(This graph does not depict N/A responses)



Figures 37 and 38 show the results for questions about conference and course attendance. Respondents were asked to rate whether they were able to attend conferences and courses of their choice. Only 5% or fewer of all respondents from each rotation said they were never allowed, but more than 70% could usually or always attend.

Figure 37: Were you able to attend the conferences you wanted to?

(This graph does not depict N/A responses)

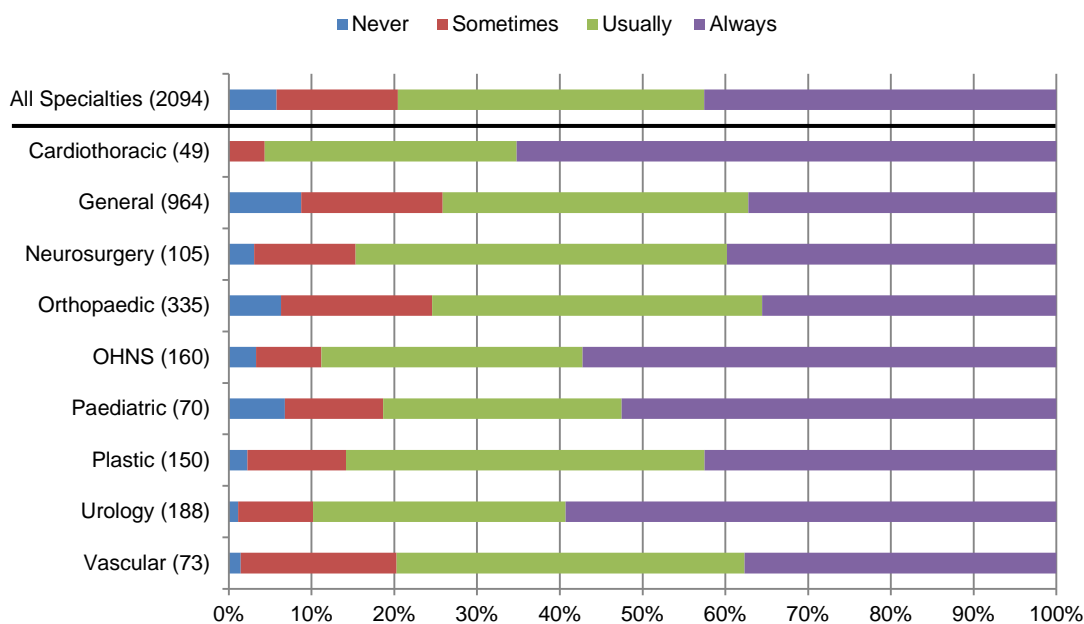
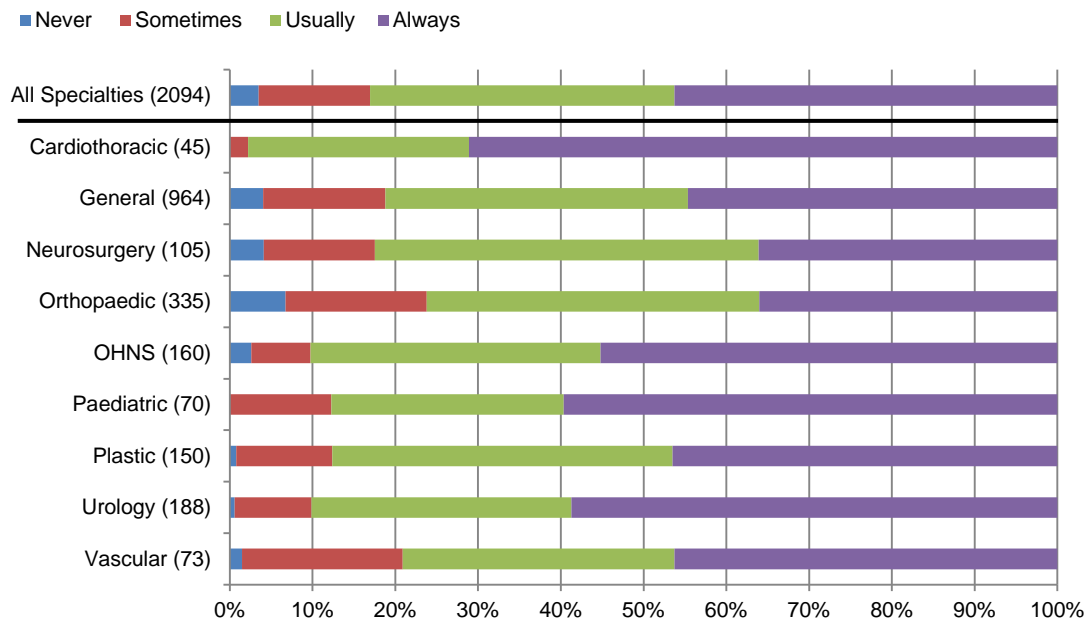


Figure 38: Were you able to attend the courses you wanted to?

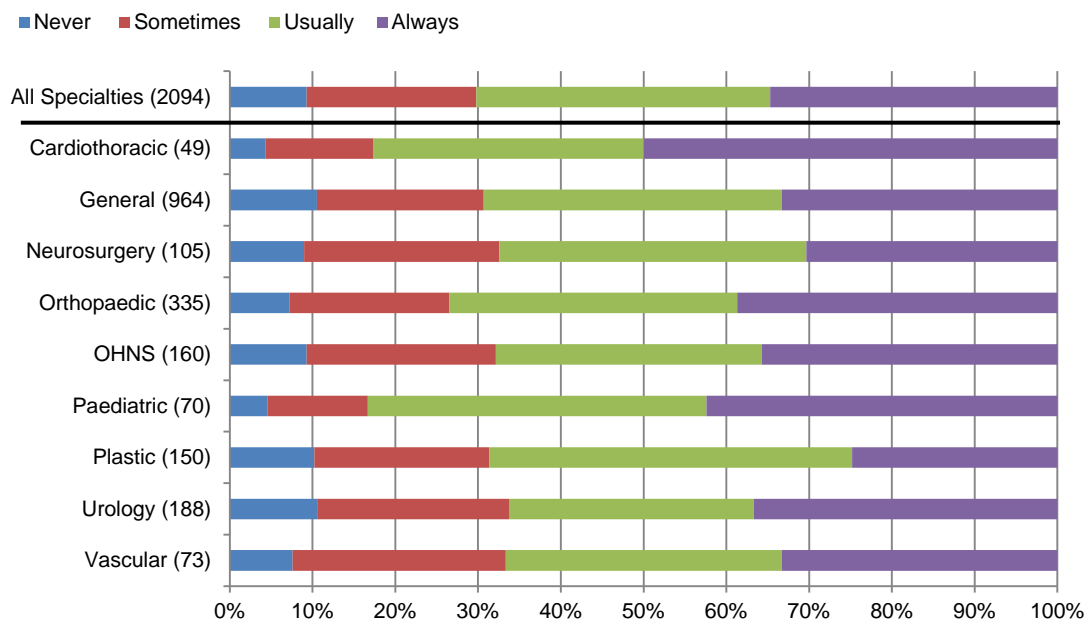
(This graph does not depict N/A responses)



Respondents were asked to rate if any research projects they undertook or wanted to undertake were supported by the Consultants on the unit. Figure 39 shows that the majority of respondents felt supported in their research.

Figure 39: Was there support for research projects?

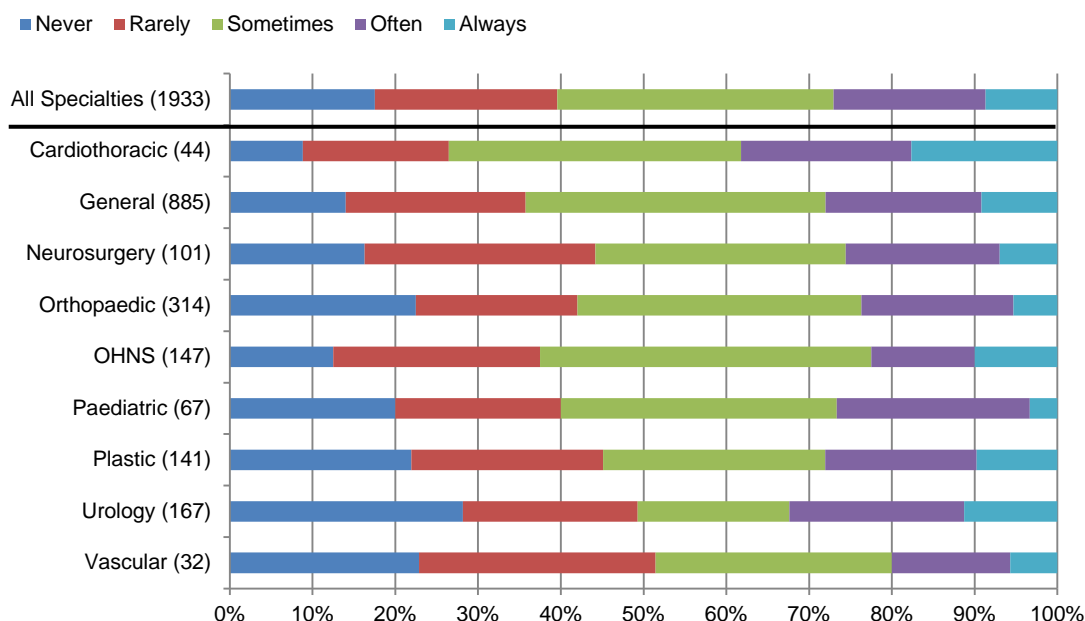
(This graph does not depict N/A responses)



More than half (50.4%) the individual respondents did not have fellows on their unit, therefore no potential barriers were presented. Of those respondents who did have a fellow on rotation, it was most frequently reported that a fellow was sometimes a barrier to gaining experience (16.6%). This can be seen in Figure 40. When asked to comment, responses generally fell into one of two categories: fellows who were helpful and were a great source of guidance and teaching, and those who Trainees felt were a hindrance to trainee learning. A summary of the comments can be seen below.

Figure 40: Was the presences of fellows on the unit a barrier to gaining experience?

(This graph does not depict N/A responses)



Comments regarding fellows being a barrier to gaining experience

The most common comment about fellows on the unit was that their presence directly decreased the operating time of Trainees (63 respondents). There were 29 respondents who stated that fellows were given preference, and there were a further 24 comments from respondents that indicated fellows were denying the Trainees opportunities to learn.

In contrast, 55 respondents indicated that the fellows were positively contributing to training. There were also nine Trainees who said that they were the fellow.

Positive comments about fellows can be summarised as follows:

- ❖ *The fellow was co-operative and collegiate with the Trainee*
- ❖ *Fellows do not create a barrier*
- ❖ *The fellow could be useful on some circumstances*
- ❖ *The presence of fellows positively impacted training*
- ❖ *The absence of a fellow was a barrier to learning*

A summary of comments regarding the negative impact fellows have on Trainees are as follows:

- ❖ *There is not enough work for both fellows and Trainees*
- ❖ *The knowledge and experience of the fellow is not sufficient for the role they are required for*
- ❖ *The fellow negatively contributes to training*
- ❖ *If there is no fellow on the unit, there is a positive impact on training*
- ❖ *The fellow leaves the trainee with all the after-hours work or on-call duties*
- ❖ *Consultants or other Trainees cause barriers to learning*
- ❖ *Non-theatre work limits operating time*
- ❖ *Getting leave for courses was an issue due to the non-Trainees taking leave*
- ❖ *There is not a clear definition of what the role of the fellow is*
- ❖ *The fellow had their own team or clinic*
- ❖ *Bullying was a factor*
- ❖ *The fellow had a sense of entitlement over the Trainee*
- ❖ *There was no in-house formal teaching on the job or in tutorials*
- ❖ *Trainees are being passed despite having inadequate skills*
- ❖ *Trainees' training is delayed or deferred as a result of fellows on the unit*
- ❖ *The fellow caused irregular rosters*
- ❖ *Budget constraints caused issues in learning*
- ❖ *The unit was poorly organised*
- ❖ *The fellow leaves the Trainee with no supervision or support*
- ❖ *The fellow's focus was elsewhere*

Objectives and assessments

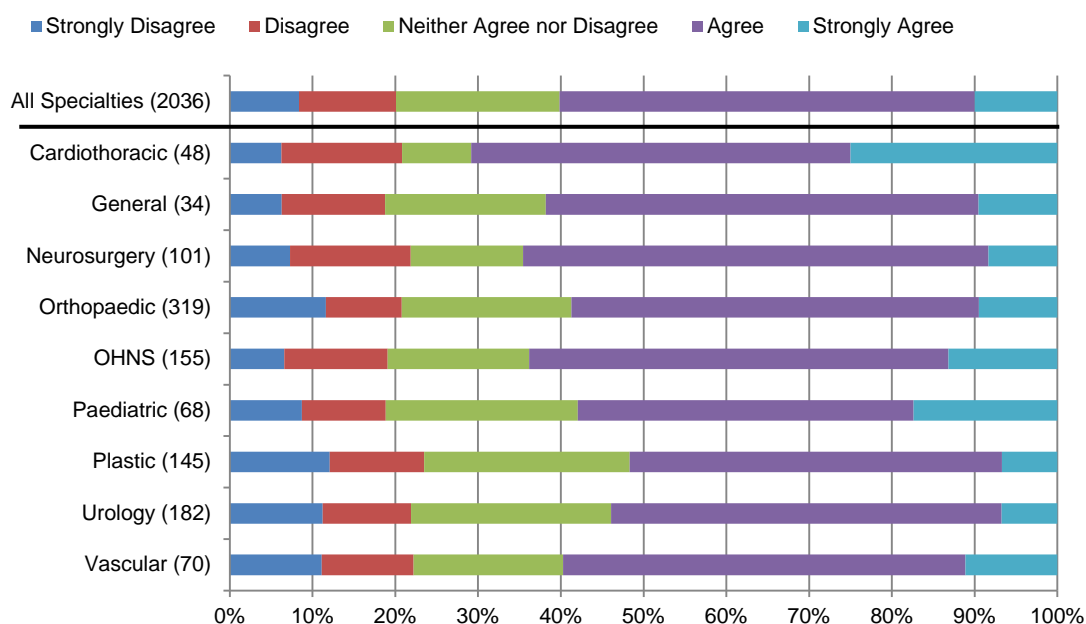
A series of questions in each survey asked respondents to rate the effectiveness of objective setting and the quality or constructiveness of assessments. Results are detailed in Figures 41-53.

Appropriate Objectives were set at the beginning of the term

Nearly 60% of respondents agreed or strongly agreed that objectives were clearly set at the beginning of each rotation. However, about 20% did not agree this had happened. A further 19.5% provided a neutral answer suggesting that they may have been unclear of the expectation to set objectives or that they felt it was not done in an appropriate manner.

Figure 41: Appropriate objectives were set at the beginning of the term

(This graph does not depict N/A responses)

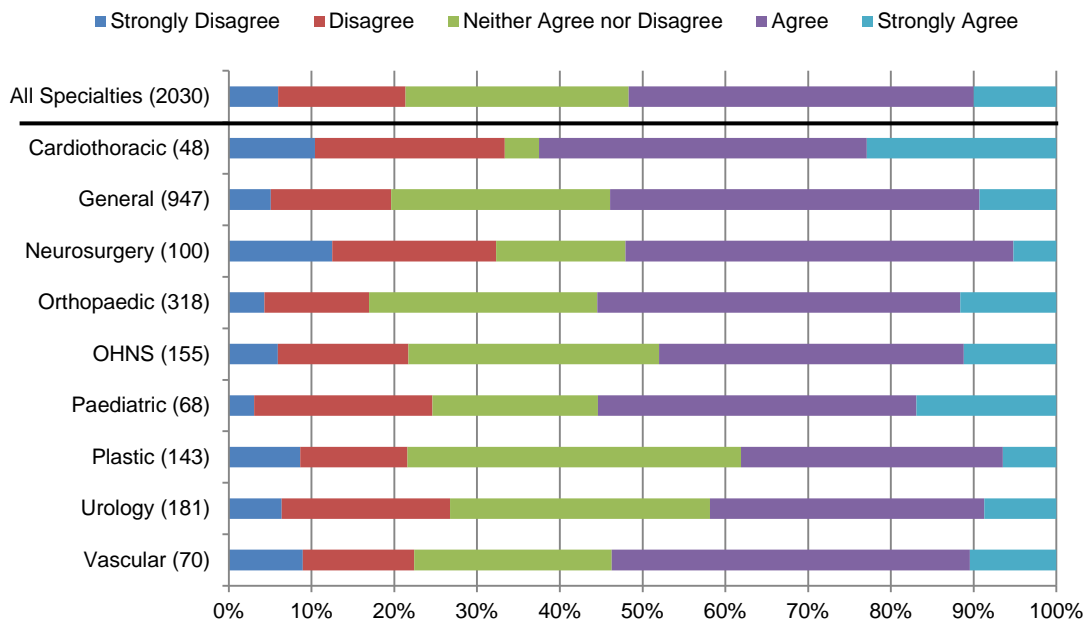


My agreed learning objectives were a priority with the team

Nearly 50% of respondents rated their team as prioritising their learning objectives. While a quarter provided a neutral answer, the remaining quarter did not feel supported by their team when it came to learning objectives. Figure 42 shows the ratings.

Figure 42: My learning objectives were a priority with the team

(This graph does not depict N/A responses)

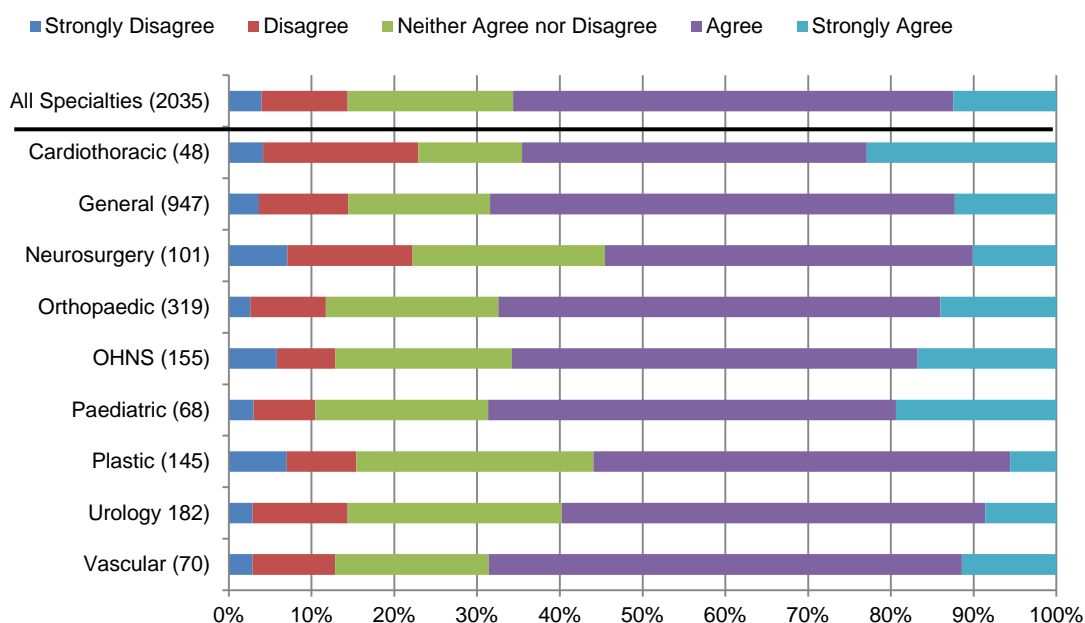


Learning Objectives

Responses to whether learning objectives were achieved during the rotation reflect similar ratings from the previous two tables. 64.2% of respondents agreed they had achieved their learning objectives, but just under 20% provided a neutral response and 16.3% did not feel they had achieved their objectives.

Figure 43: I achieved my learning objectives

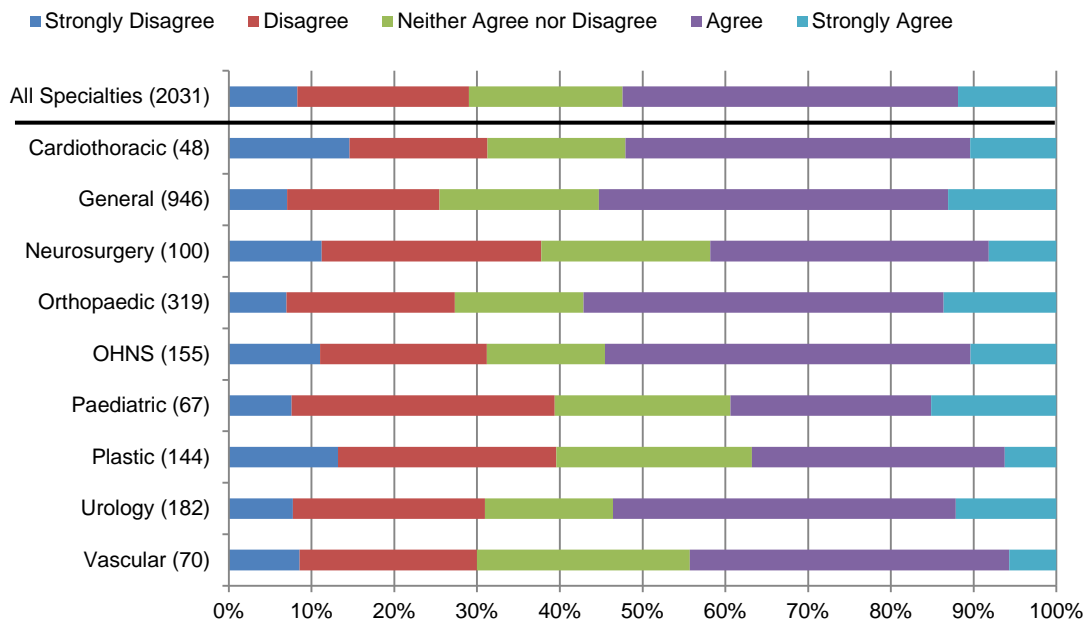
(This graph does not depict N/A responses)



Study and Research

Figure 44: I had sufficient time for study and research

(This graph does not depict N/A responses)



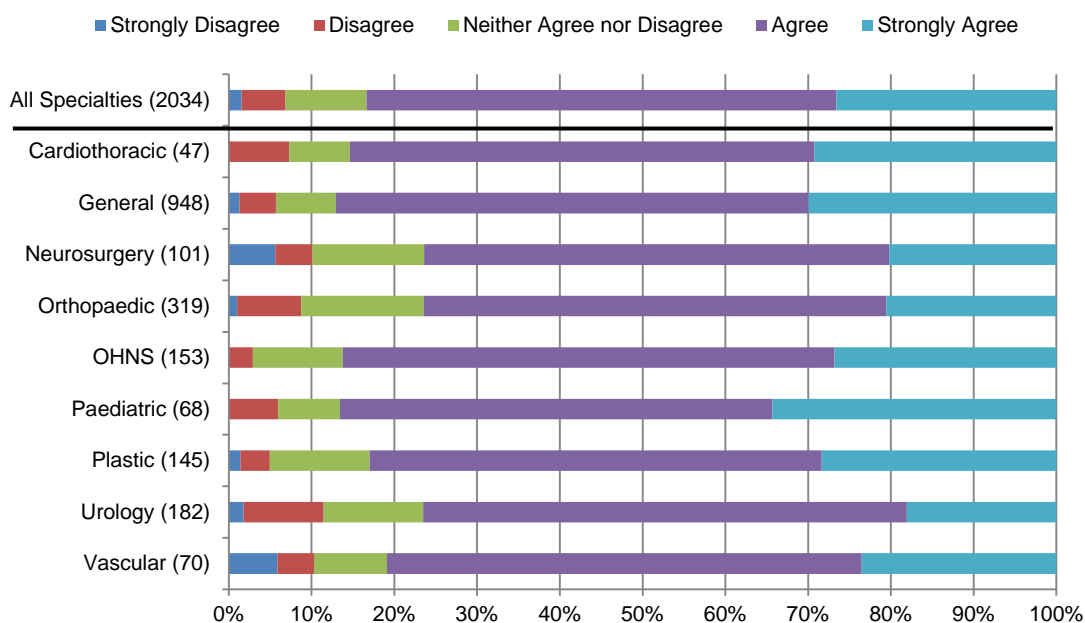
The Mid-Term Assessment meeting was easy to arrange

The majority of respondents agreed the mid-term assessment meeting was easy to arrange. It should be noted that not all specialties require a mid-term assessment. Results can be seen in Figure 45.

Of those that did attend a mid-term meeting, more than 70% agreed that it was a constructive and fair experience. Results for this can be seen in Figure 46.

Figure 45: The mid-term assessment meeting was easy to arrange

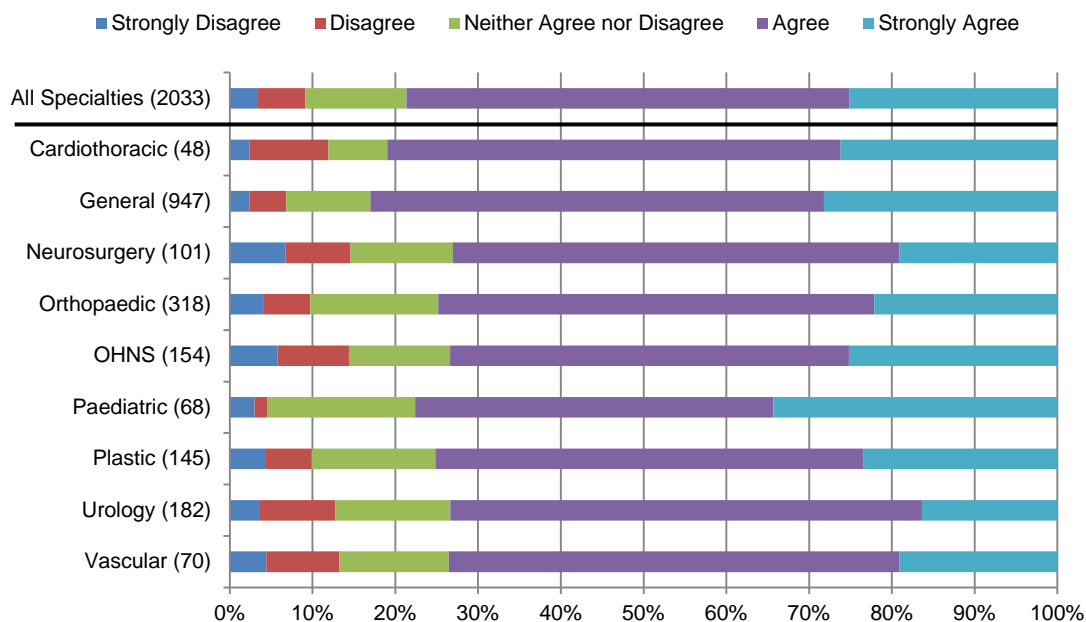
(This graph does not depict N/A responses)



The Mid-Term Assessment was a constructive and fair experience

Figure 46: The mid-term assessment meeting was a constructive and fair experience

(This graph does not depict N/A responses)



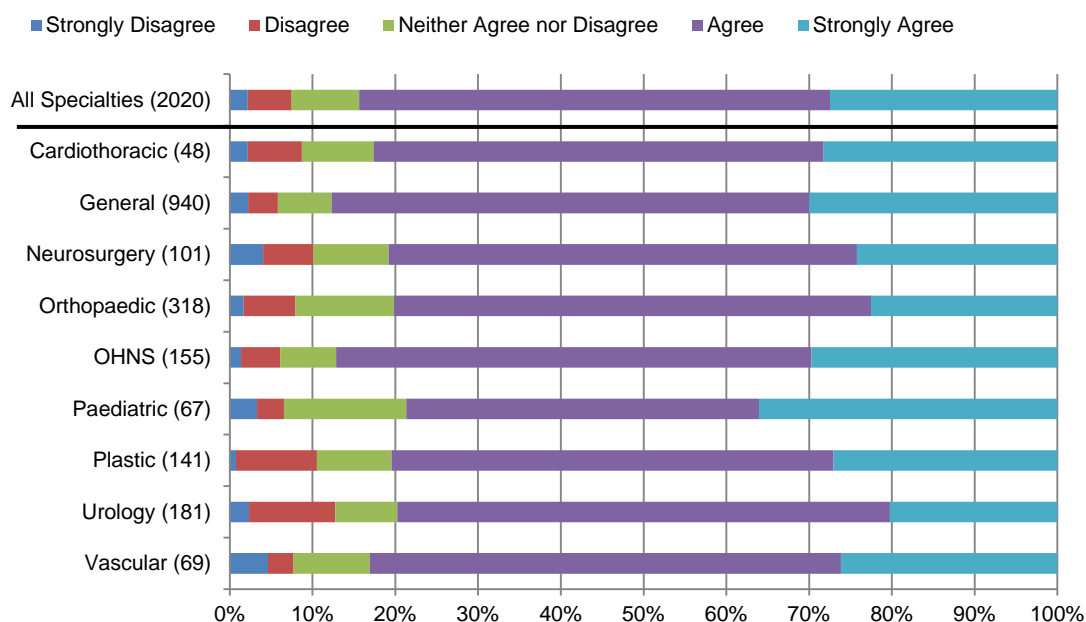
Figures 47 and 48 show responses regarding the End of Term assessment. While the majority agree that the meeting was easy to arrange, 4.1% reported that the end of term meeting did not occur. All specialties require the Supervisor of Training and Trainee meet to discuss the end of term assessment.

Again, the majority believed the assessment to be a fair and constructive experience.

The End-Of-Term Assessment meeting was easy to arrange

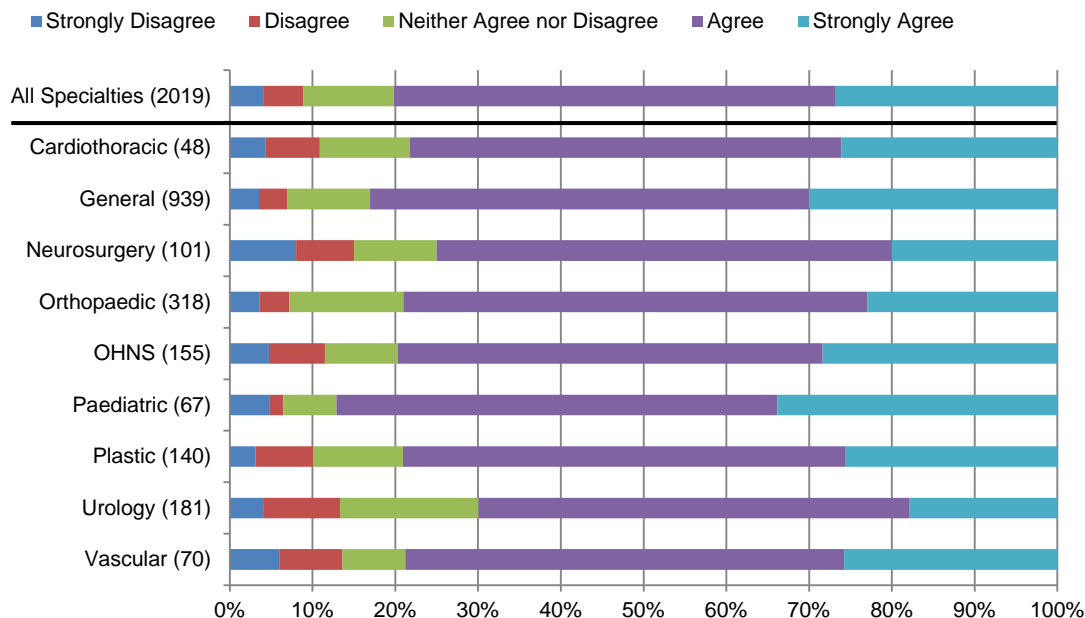
Figure 47: The end-of-term assessment meeting was easy to arrange

(This graph does not depict N/A responses)



The End-Of-Term Assessment was a constructive and fair experience

Figure 48: The end-of-term assessment meeting was a constructive and fair experience
(This graph does not depict N/A responses)

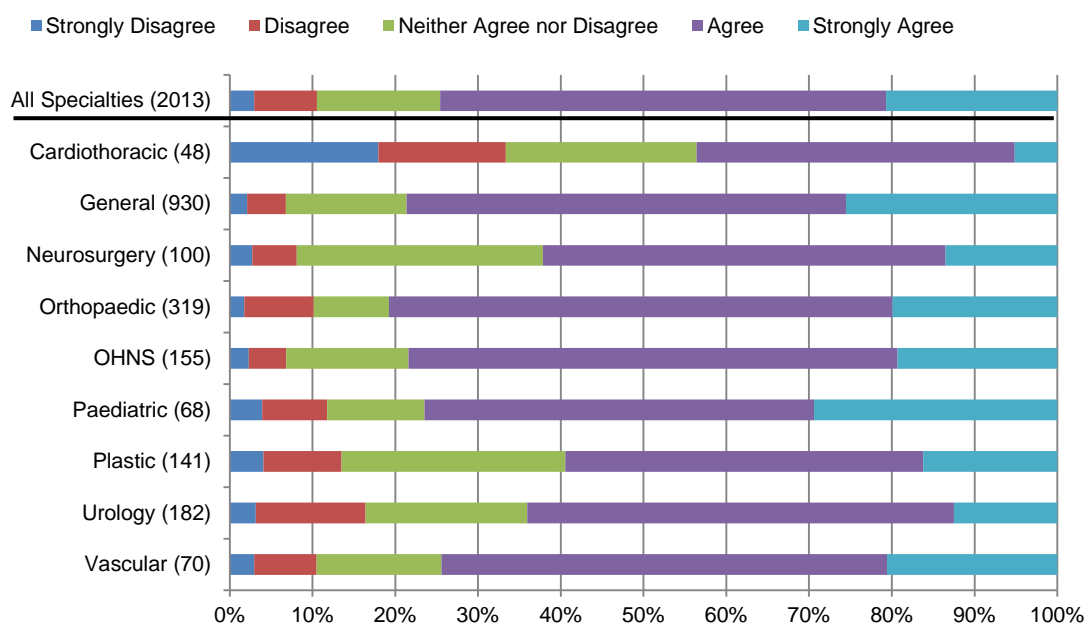


Direct Observation of Procedural Skills (DOPS) is not performed by all levels in all specialties, so there is a much higher rate of “Did Not Occur” answers.

Figures 49 and 50 show respondents ratings for whether DOPS were easy to arrange and a constructive learning experience. There is general agreement that DOPS were easy to organise and a constructive learning experience.

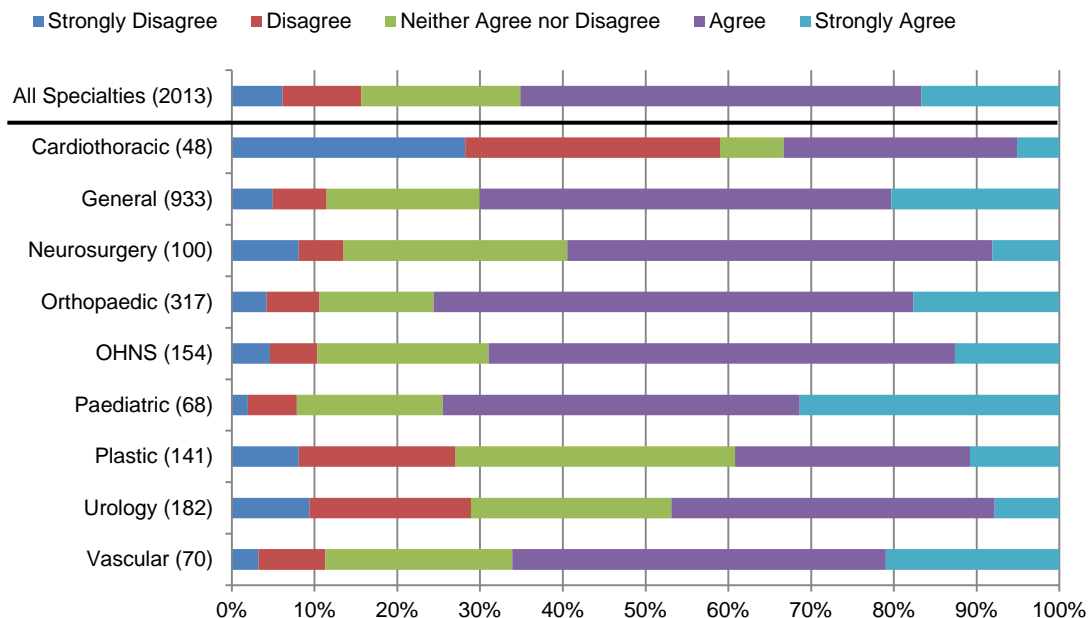
The DOPS Assessment was easy to arrange

Figure 49: DOPS assessment was easy to arrange
(This graph does not depict N/A responses)



The DOPS Assessment was a constructive learning experience

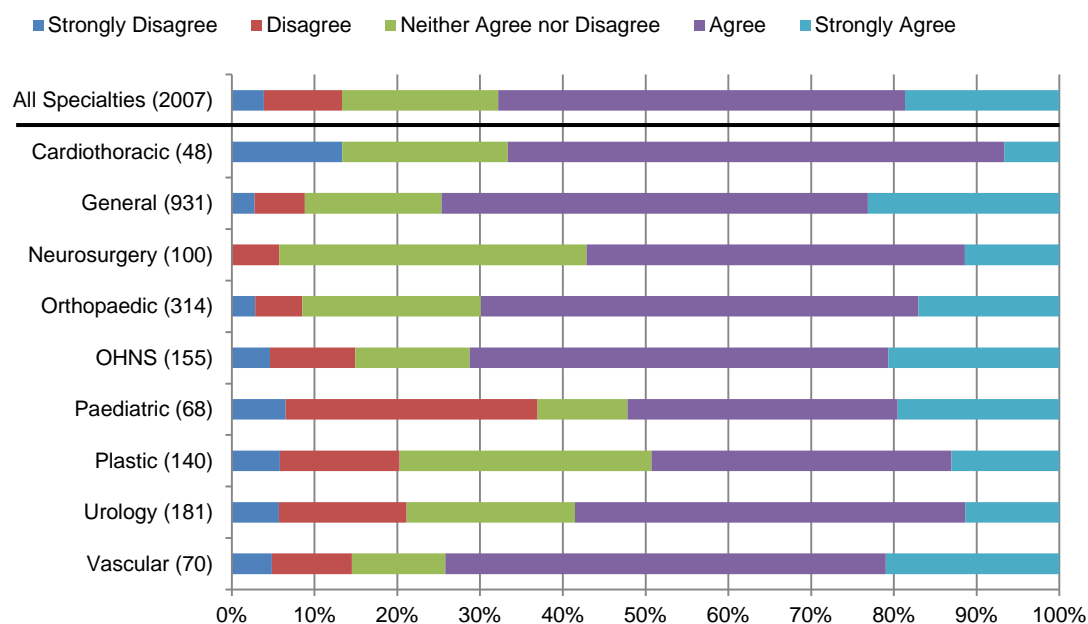
Figure 50: The DOPS assessment was a constructive learning experience
(This graph does not depict N/A responses)



Mini Clinical Examination (Mini-CEX) is not performed by all levels in all specialties hence there is a much higher rate of "Did Not Occur" answers. Figures 51 and 52 show respondents ratings for whether Mini-CEX were easy to arrange and a constructive learning experience. There is general agreement that Mini-CEX were easy to organise and a constructive learning experience.

The Mini-CEX Assessment was easy to arrange

Figure 51: The Mini-CEX assessment was easy to arrange
(This graph does not depict N/A responses)



The Mini-CEX Assessment was a constructive learning experience

Figure 52: The Mini-CEX assessment was a constructive learning experience
(This graph does not depict N/A responses)

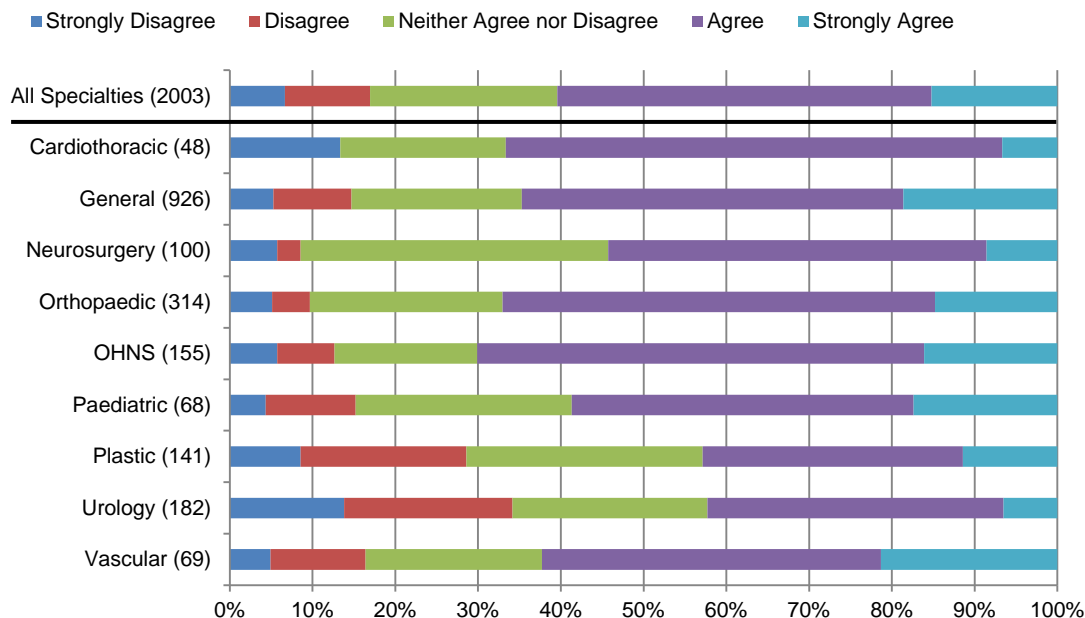
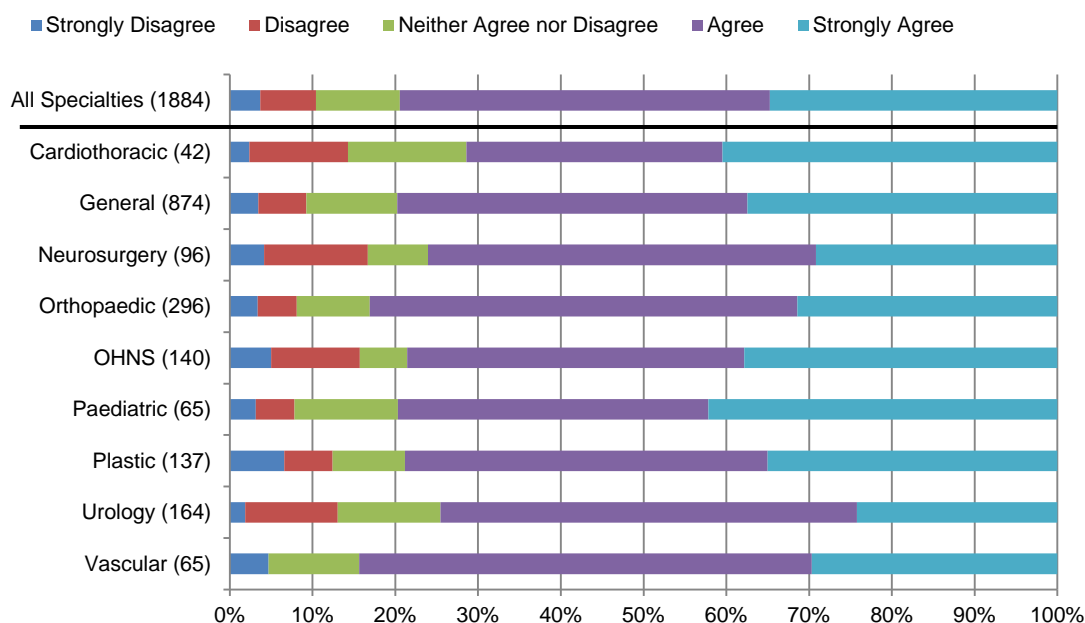


Figure 53 gives the overall ratings on whether the rotation provided a good learning experience. As can be seen, nearly 80% agree or strongly agree that their rotation was. Just over 10% disagreed that this was the case, and 10% of respondents gave a neutral answer.

Overall, this rotation was a good learning experience

Figure 53: Overall, this rotation was a good learning experience
(This graph does not depict N/A responses)



Bullying and Harassment

The majority of surveys were conducted before the formation of the Expert Advisory Group's (EAG) investigation into bullying, discrimination and sexual harassment in the practice of surgery. One survey was conducted four months after its formation and one was conducted a few months after the release of its report and the subsequent RACS Action Plan. The data collected by the EAG, indicates there may have been under reporting of these issues in these surveys. In subsequent surveys conducted since 2016, this section has been expanded to include more detailed questions.

Aggregated responses show 18.5% of Trainees reported they had experienced bullying or harassment (Table 15). There was no distinction in the questions between being subject to or witnessing the inappropriate behaviour.

Of 469 respondents who reported experiencing bullying or harassment, 10% wished to be contacted by a RACSTA representative. Table 16 has these results.

Table 15: Bullying and Harassment

	Number of Respondents	Yes	No
All Specialties	2,033	18.5%	81.5%
Cardiothoracic Surgery	48	27.1%	72.9%
General Surgery	936	16.1%	83.9%
Neurosurgery	101	27.7%	72.3%
Orthopaedic Surgery	322	16.1%	83.9%
OHNS	192	33.9%	66.1%
Paediatric Surgery	69	23.2%	76.8%
Plastic Surgery	145	24.8%	75.2%
Urology	186	19.4%	80.6%
Vascular Surgery	70	21.4%	78.6%

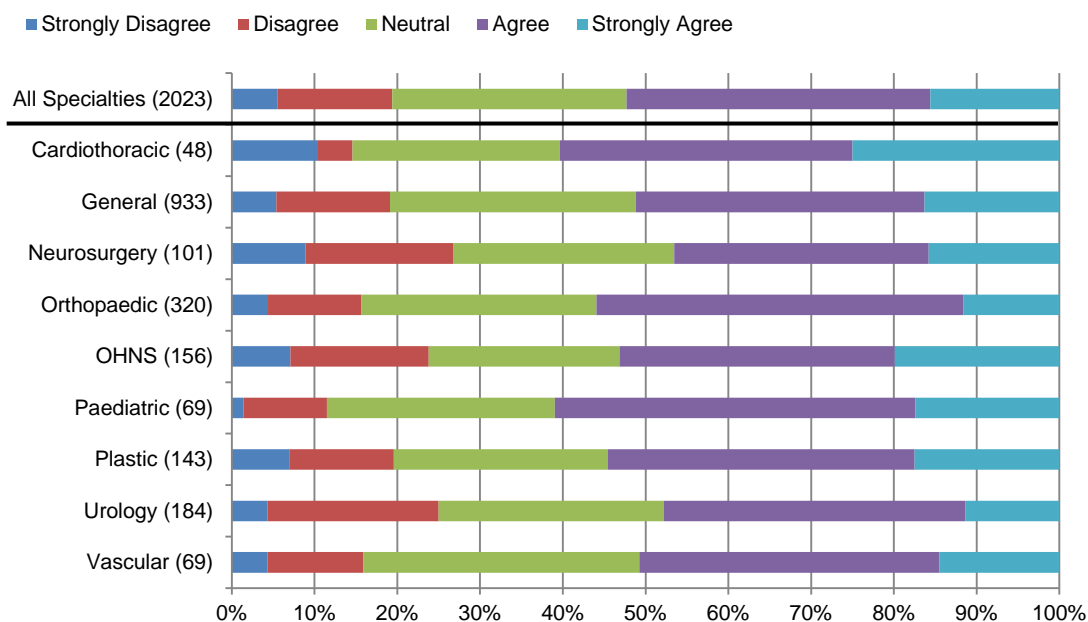
Table 16: Respondents wanting RACSTA contact

	Number of Respondents	Yes	No
All Specialties	469	10.0%	90.0%
Cardiothoracic Surgery	15	13.3%	92.0%
General Surgery	199	8.0%	92.0%
Neurosurgery	34	14.7%	85.3%
Orthopaedic Surgery	69	8.7%	91.3%
OHNS	38	13.2%	86.8%
Paediatric Surgery	18	11.1%	88.9%
Plastic Surgery	38	18.4%	81.6%
Urology	40	2.5%	97.5%
Vascular Surgery	18	16.7%	83.3%

Subjective Evaluation of the Term

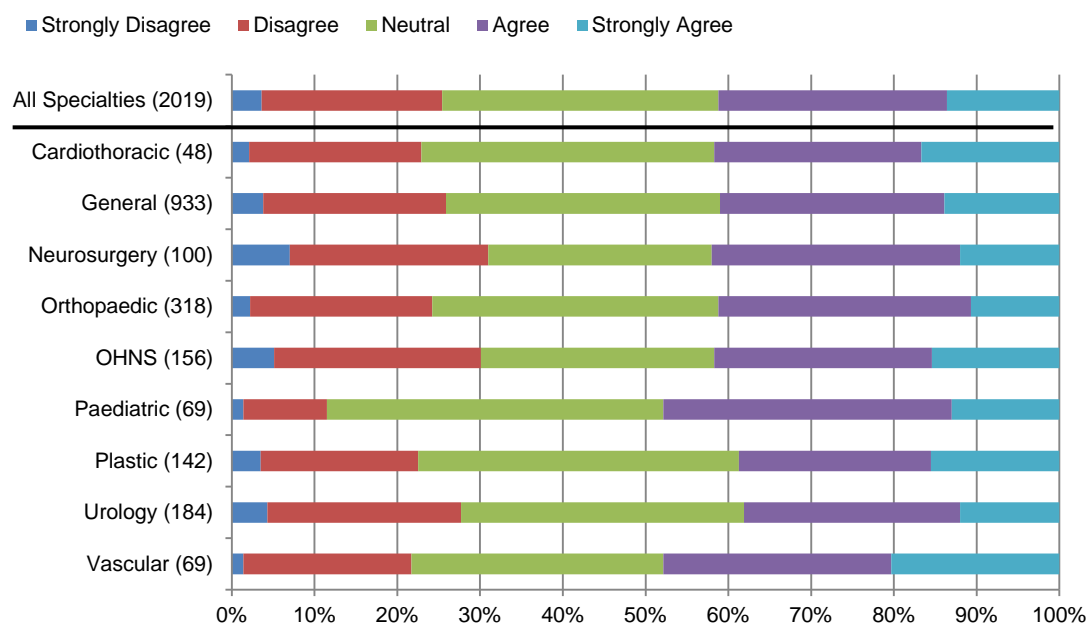
Trainees were asked if this rotation offered better training than most. More than half the respondents agreed that it was. There were a large number of neutral answers and nearly 20% disagreed with the statement. Figure 53 summarises the results.

Figure 53: This term offered better training than most



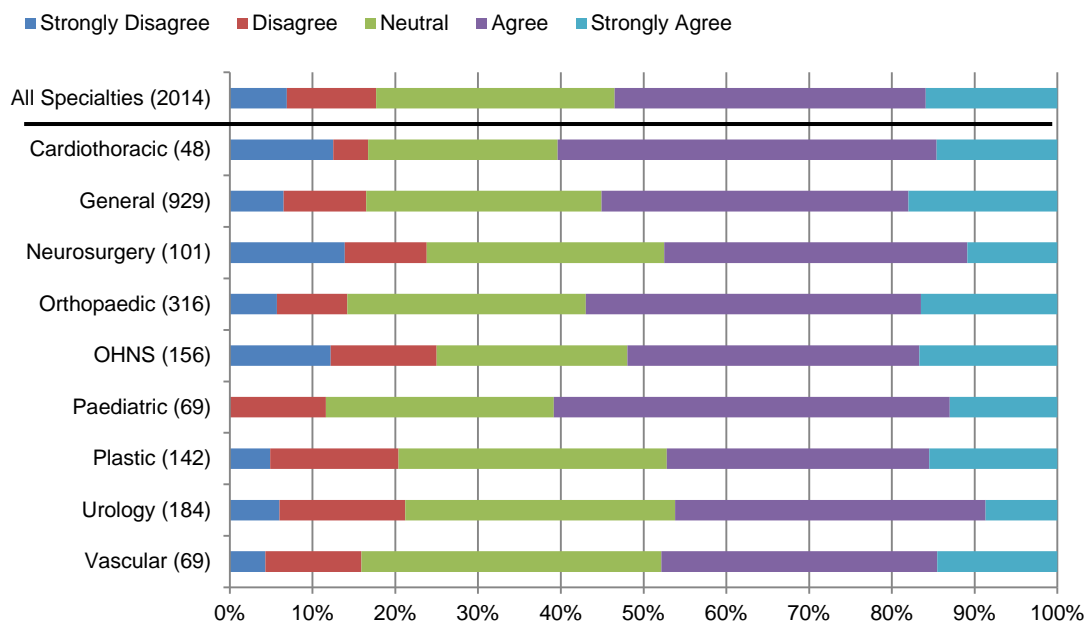
Trainees were asked if this rotation was busier than most. More than 40% of the respondents agreed that it was. There were a large number of neutral answers and about 25% disagreed with the statement. Figure 54 summarises the results.

Figure 54: This term was busier than most



Trainees were asked if this rotation was more enjoyable than most. More than half the respondents agreed that it was. There were a large number of neutral answers and under 20% disagreed with the statement. Figure 55 summarises the results.

Figure 55: This term was more enjoyable than most



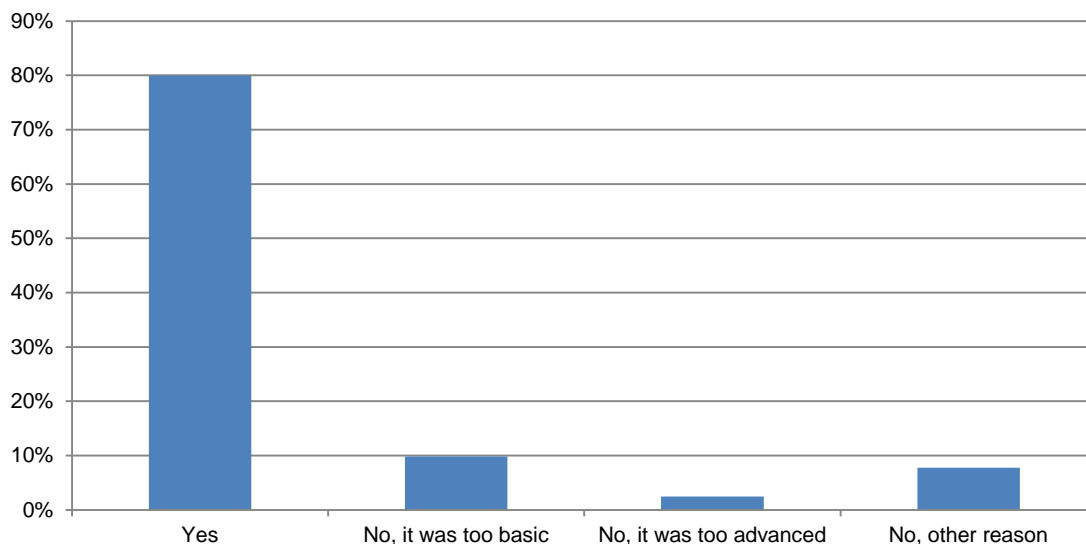
Trainees were asked to rate how working hours related to fatigue and patient safety. The wording of this question was changed from the Term 2 2013 survey, so the results in Table 17 below show a combined report. When the responses from "Too Many Hours" and "Unacceptable" are combined, just over 30% of respondents believed that they were fatigued or that patient safety was compromised.

Table 17: Working hours and fatigue

	Number of Respondents	Not Enough Hours	Too Many Hours	About Right / Acceptable	Often Unacceptable	Sometimes Unacceptable
All Specialties	2024	2.3%	9.3%	66.7%	4.6%	17.1%
Cardiothoracic	43	4.7%		69.8%	11.6%	14.0%
General	934	2.7%	8.5%	69.2%	4.6%	15.1%
Neurosurgery	101	1.0%	12.9%	51.5%	5.9%	28.7%
Orthopaedic	320	2.2%	5.9%	70.3%	3.1%	18.4%
OHNS	156	4.5%	14.1%	60.3%	3.8%	17.3%
Paediatric	69		11.6%	59.4%	8.7%	20.3%
Plastic	143	0.7%	11.2%	67.1%	4.9%	16.1%
Urology	184	1.6%	8.7%	65.8%	4.9%	19.0%
Vascular	69		14.5%	63.8%	2.9%	18.8%

Trainees were asked to rate the appropriateness of the rotation for their SET Level. A total of 2,024 Trainees responded to this question and the results are in Figure 56. While the majority were satisfied, there was a minority that found it too basic or too advanced. The qualitative data from those that thought the term was not appropriate is below.

Figure 56: Do you think that this term was appropriate for your current SET level?



There were more than 30 comments from Trainees indicating that they were not given the opportunity to learn or operate in a capacity appropriate to their SET level, which limited their learning opportunities.

A summary of other negative comments follows:

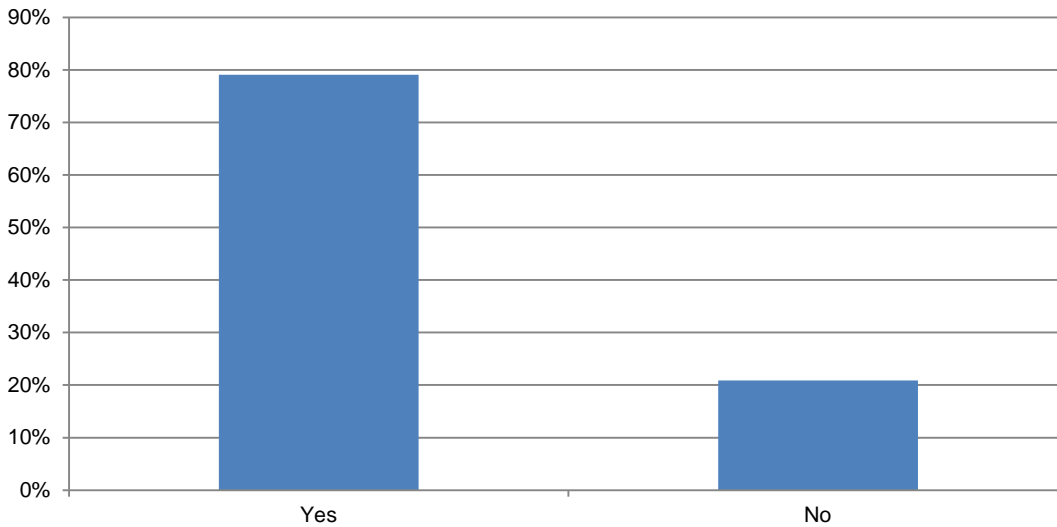
- ❖ *IMGs/fellows or junior consultants were causing barriers to the learning experience*
- ❖ *There was not enough focus on training and/or teaching or there was a lack of support from supervisors*
- ❖ *A private hospital was not an appropriate training setting*
- ❖ *The workload was insufficient for effective learning*
- ❖ *There was not enough variety in the cases, with too much of one type of procedure or too much focus on a sub-specialty*
- ❖ *The learning objectives were achieved too quickly meaning that the SET level was too high and the training didn't push the Trainee*
- ❖ *Some of the skills taught were not applicable for the Trainee*
- ❖ *There was a lack of acute, specialty or elective operations*
- ❖ *The employment agreement and administrative arrangements limited learning opportunities*
- ❖ *Budget constraints within the hospital limited learning opportunities*
- ❖ *The term was too advanced*

Would you recommend this post to other trainees?

The results shown in Figure 57 are reflective of the results in the previous Figure 56. A similar number of trainees who thought it was appropriate for their level of training would recommend it to others at the same level.

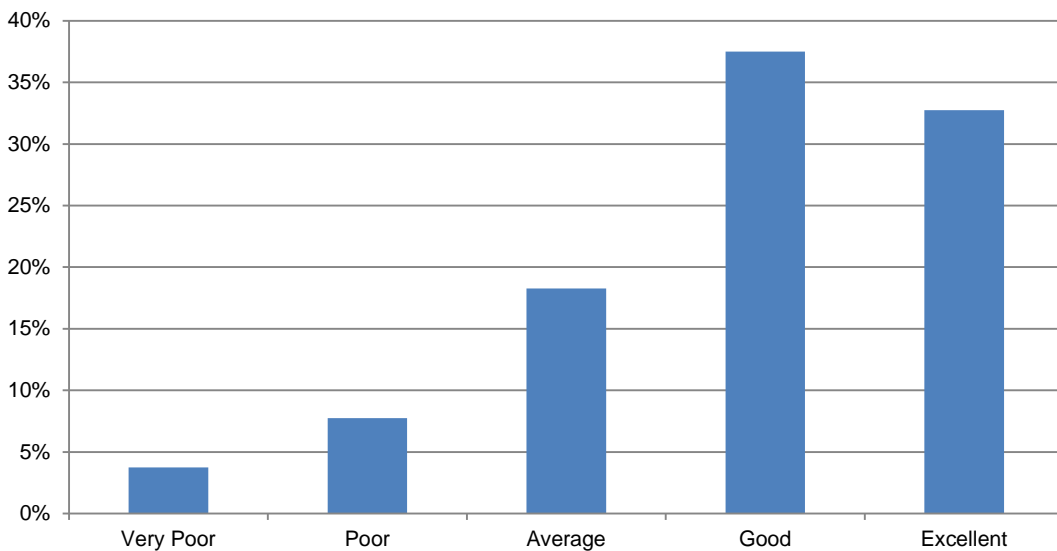
Total number of all Trainees to answer this question: 2,024

Figure 57: Would you recommend the post to other trainees at your level?



Trainees were asked to provide an overall rating for the rotation. Total number of all Trainees to answer this question was 1,872. 11% rated it as poor or very poor. The most common response was Good (37.5%). A summary of comments is provided below.

Figure 58: Overall, how would you rate this rotation?



Trainees appear to rate the rotation well, with more than 60 Trainees indicating they were well supported by their supervisors or that it was an excellent or great rotation. There were a further 20 respondents who wrote comments from respondents that noted the term was a good learning opportunity and good operative experience.

Other positive comments were:

- ❖ *There was good exposure to a variety of cases*
- ❖ *There were good learning opportunities*
- ❖ *No fellows in the term positively impacted training*
- ❖ *The term was good for study*

However, there were a number of negative comments which can be summarised by the following statements:

- ❖ *The Trainee was not well supported by the supervisor*
- ❖ *There was a lack of operating time, especially as the primary operator*
- ❖ *There were roster or staffing issues*
- ❖ *The presence of fellows, unaccredited registrars and IMG's limited operating time and learning opportunities*
- ❖ *High ward, inpatient and outpatient responsibilities assigned to Trainees caused barriers to learning*
- ❖ *There was too much administrative work and the hospitals had poor administrative organisation and were unsupportive, which caused barriers to learning*
- ❖ *Bullying negatively impacted the experience of the term*
- ❖ *There was no formal training, rostered training or study time made available*
- ❖ *Employment agreements limited working time, resulted in unpaid work or prevented the accumulation of leave*
- ❖ *There were heavy on-call requirements of the Trainee causing excessive fatigue*
- ❖ *Private health care is a barrier to learning for Trainees*
- ❖ *There was a lack of variety or limited/no access to a number of procedures*
- ❖ *The post was more suited to a lower SET level*
- ❖ *Trainees were not the priority within the hospital*
- ❖ *The workload and lack of elective lists was insufficient for effective learning*
- ❖ *It was difficult to get the required number of acute cases*
- ❖ *The rotation was more service oriented than training oriented*
- ❖ *The post would be better suited to another specialty or SET level*
- ❖ *The post is not recommended to any Trainee*
- ❖ *The rotation plan for the term did not meet the needs of training*
- ❖ *There was too much supervision or operating as assistant/observer which limited the ability to learn how to operate independently*
- ❖ *The Trainee was performing duties that were below their current training level*
- ❖ *Having to prepare for exams shifts the focus from training (1 comment)*
- ❖ *There were no or limited clinics or on-call time*

Future Rotations

Trainees were asked whether they would you be interested in being involved in outreach or international work within their Specialty as a Trainee. The total number of Trainees to answer this question was 1,202. This question was first asked in Term 1 2013.

While nearly 80% of trainees responded that they would be interested, there are known difficulties for specialty boards in providing this.

Table 18: Interest in outreach or international work

	Number of Respondents	Yes	No
All Specialties	1,202	79.7%	20.3%
Cardiothoracic Surgery	28	82.1%	17.9%
General Surgery	565	76.8%	23.2%
Neurosurgery	60	75.0%	25.0%
Orthopaedic Surgery	187	79.7%	20.3%
OHNS	103	81.6%	18.4%
Paediatric Surgery	44	88.6%	11.4%
Plastic Surgery	96	91.7%	8.3%
Urology	85	87.1%	12.9%
Vascular Surgery	34	64.7%	35.3%