ANZTBCRS

Australia and New Zealand Training Board in Colon and Rectal Surgery

Regulations and Policies

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SECTION 1: ANZTBCRS REGULATIONS

Post Fellowship training in colorectal surgery is a two-year course following completion of Pre-Fellowship training in general surgery and success at the Part II FRACS examination. It is administered by the Australia and New Zealand Training Board in Colon and Rectal Surgery (ANZTBCRS).

These regulations have been approved by the CSSANZ Council and Executive of the Colon and Rectal Surgery Section and may be updated and amended from time to time as the ANZTBCRS deem necessary provided that any changes to these regulations are to be resubmitted to the CSSANZ Council and Executive of the Colon and Rectal Surgery Section for approval.

Approved changes will be applied as the ANZTBCRS require and any amendments will be incorporated into future versions of this document.

1. TRAINING BOARD GOVERNANCE

1.1. Membership of the ANZTBCRS

The ANZTBCRS will be comprised of:

1.1.1. Six members ("ordinary members") whose appointment is approved by the Executive of the Colon and Rectal Surgery Section of the College ("Section"), and by the Council of the Colorectal Surgical Society of Australia and New Zealand ("CSSANZ").

1.1.1.1. These six members consist of three members representing the Section and three members representing CSSANZ.

1.1.1.2. CSSANZ or Section members will be invited to apply for a corresponding position on the ANZTBCRS when a vacancy occurs. The applicant must be a full and financial member of both the Section and the Society. Expressions of Interest will be forwarded to the Chair, ANZTBCRS. This application will be assessed by the Membership Sub-Committee of ANZTBCRS, comprising the Chair ANZTBCRS, the President CSSANZ and the Chair Section. This Sub-Committee will then nominate the new member for selection to the ANZTBCRS and this nomination is then ratified by the ANZTBCRS, the CSSANZ Council and the Executive of the Section.

1.1.2. The President of CSSANZ (2-year term with full voting rights).

1.1.3. The Chair of the Section (3-year term with full voting rights).

1.1.4. The Chair of the CSSANZ Research Support Committee (co-opted, 4-year term with full voting rights).

1.1.5. Any other person(s) co-opted.

1.1.5.1. The Chair ANZTBCRS has the right to co-opt any suitable person to the Committee.

1.1.5.2. Any co-opted appointee (with the exception of Chair of the CSSANZ Research Support Committee above) will have no voting rights but will be co-opted for activities such as program site inspections and applicant interviews.

1.1.5.3. The term of appointment will be for 3 months, renewable for additional 3 monthly terms if appropriate.

1.2. Chair of the ANZTBCRS

1.2.1. The Chair will be elected by, and from within, the six nominated ANZTBCRS members.

1.2.2. The term of appointment shall be 2 years.

1.2.3. The Chair is not required to hold executive office in either the Section or CSSANZ.

1.3. Chair-Elect

1.3.1. The Chair-Elect will be appointed usually at the Training Weekend Board meeting twelve (12) months before the current Chair steps down.

1.3.2. The Chair-Elect will usually be the next most senior member of the ANZTBCRS.

1.3.3. The current Chair nominates this member as Chair-Elect and the ANZTBCRS then votes on this nomination.

1.3.4. If not approved by a majority vote, then the Chair-Elect will be chosen by a confidential vote of all ANZTBCRS members.

1.3.5. In the situation of a tied vote, the incumbent Chair has the casting vote.

1.3.6. This final decision is then submitted to the Executive of the Section and the Council of CSSANZ for ratification.

1.3.7. The successful nomination will then spend 12 months as Chair-Elect shadowing the current Chair prior to taking over as Chair for 2 years.

1.3.8. The previous Chair will then remain on the ANZTBCRS for 12 months with full voting rights before stepping down.

1.4. Terms of Office

1.4.1. Each member of the ANZTBCRS is elected for a 4-year term.

1.4.2. Each member is eligible to re-apply to the Membership Sub-Committee for a further 4-year term to a maximum of 3 terms or 12 years.

1.5. Portfolios

The Chair may delegate portfolios to ANZTBCRS members including, but not limited to, the following:

1.5.1. Training Weekend: A 3-day meeting will be held annually at which the trainees will be asked to present on set topics with accompanying written manuscripts.

1.5.1.1. The meeting will be convened by one or more of the members of the ANZTBCRS each year, with the location agreed upon by the ANZTBCRS and any industry-sponsors.

1.5.1.2. The topics will be allocated by the ANZTBCRS member responsible for convening of the Training Weekend, derived from the 3-year study syllabus. The syllabus will form part of the ANZTBCRS Exam for trainees at the end of second year of training.

1.5.2. ANZTBCRS Representative on CSSANZ Research Committee

1.5.3. Hospital Inspections

1.5.4. Logbooks/Procedure Based Assessments

1.5.5. Exams

1.5.6. Interviews

1.5.7. Sign off

1.5.8. Additional Courses / Workshops

1.5.9. Prizes & Scholarships

1.5.10. Regulations/Handbook

1.5.11. Evaluation Reports

1.5.12. Trainees' Liaison

1.5.13. Financial Matters

1.5.14. Research

1.6. ANZTBCRS Meetings

The ANZTBCRS may meet at any time during the year but will always meet during the Annual Scientific Congress and the Spring Colorectal Surgery Meeting, as well as at the Training Weekend, at which time the office bearers will be appointed. Teleconferences may also be conducted in between as required.

1.7. Responsibilities of the ANZTBCRS

1.7.1. Establish and supervise post fellowship training in colorectal surgery in Australia and New Zealand.

1.7.2. Prepare and update the syllabus for the Post Fellowship Training Program.

1.7.3. Advise the Executive of the Section and the Council of CSSANZ on any matter pertaining to training in colorectal surgery.

1.8. Funding

Trainees will pay annual training fees to CSSANZ. These fees reflect the costs involved in running the ANZTBCRS Training Program.

2. TRAINING PROGRAM

2.1. OVERVIEW

2.1.1. The purpose of the Post Fellowship Training Program in Colorectal Surgery is to provide the structured educational and training experience necessary to achieve expertise in the understanding, diagnosis and management of diseases of the colon, rectum, small bowel and anus.

2.1.2. The ANZTBCRS will be responsible for the establishment and conduct of the overall training program, including specific training positions within hospitals, in colon and rectal surgery within Australia and New Zealand. The ANZTBCRS Program is an accredited RACS Post Fellowship and Training (PFET) Program.

2.1.3. A Colorectal Unit wishing to participate in the training program will apply to the ANZTBCRS for accreditation. The ANZTBCRS will inspect the Unit prior to accreditation being given. Provisional accreditation may be given prior to the inspection. (refer to: 4. GUIDELINES TO FACILITATE THE DEVELOPMENT OF A HOSPITAL BASED COLORECTAL SURGERY UNIT)

2.1.4. Each Unit in the training program will be required to submit an application for reaccreditation each 5 years; further accreditation will be granted only following re-inspection of that Unit.

2.1.5. A Supervisor of colorectal training ("Program Director") will be appointed to each unit. The ANZTBCRS will request the Head of each colorectal unit to nominate a Program Director who should not be the Head of the Unit but another CSSANZ member on that Unit. The Program Director will be responsible for supervising the trainee according to the requirements of the training program. This includes ensuring that adequate remuneration is provided, that working conditions meet appropriate standards, and ensuring that the trainee is exposed to a range of colorectal operative experiences. The Program Director will oversee the trainee's progress via the research project (first years), the Training Weekend paper/presentation, procedure based assessments, signing off the log book cases and providing an evaluation report on the Trainee's progress biannually. (Refer to ANZTBCRS Evaluation Form).

2.1.6. The training program as designed for each successful applicant will vary. As much as possible the needs and requests of each Trainee will be met, but this will not always be possible. Current (first year) Trainees will be offered 4 choices for their second year with the Board's aim that they will receive ONE of these four units.

2.1.7. Training will usually comprise two twelve-month periods.

2.1.8. The 2 years of training will be undertaken in at least 2 different cities1, except under exceptional circumstances. A minimum of 12 months' clinical training outside the home city is essential. Two years away is encouraged to further broaden the training experience. A minimum of one year in an Australian or New Zealand accredited unit is mandatory.

2.1.9. A year of overseas training in a pre-approved post is possible when all credentialing criteria are met. (Refer to ANZTBCRS Regulations and Policies, Section 2, 5. Overseas Training as Part of the ANZTBCRS Training Program).

[1] Where there are accredited units in two cities within the same state/region, the next placement must be outside this state/region.

2.1.10. Up to 12 months research in a colorectal research unit may be approved. This is in addition to the two years of clinical training & does not replace one clinical year.

It is not possible to commence a PhD during the first year of training. If a trainee is selected to do research during the first year of training, then this can be used to complete a PhD (final year) or to undertake a single year of a higher degree such as a Masters of Surgery. It is also possible to undertake a higher degree after the 2 clinical years but only one year of full time research is accredited towards the Australian and New Zealand Colorectal Training Program. Subsequent years would not be part of the training program, they would be classified as "unaccredited" years and the trainee can be signed off prior to completing PhD if they complete one full time year of research (with satisfactory reports from supervisors), as well as a publication and presentation emanating from project. It is also possible to undertake one year of research such as Masters of Surgery in between the 2 clinical years, but the Training Board does not recommend undertaking a PhD during this time.

Full details of the proposed research must be forwarded in advance to the ANZTBCRS, which will seek appropriate referees' reports prior to approval to commence the project. Final approval for the time spent will be given subject to a satisfactory report from the research project supervisor.

(Refer to: 5. ACCREDITATION OF RESEARCH FELLOWSHIP IN COLORECTAL SURGERY)

2.1.11. No retrospective training, either clinical or research, will be approved.

2.1.12. Trainees will be placed in hospital surgical training programs and be salaried at appropriate rates according to the contract offered by the hospital. It is likely that trainees will be required to participate in general surgical acute rosters.

2.1.13. In the event that a colorectal training post is not filled by an ANZTBCRS trainee, that position may be occupied by a non-ANZTBCRS trainee at the discretion of the unit.

2.1.14. Trainees will be required to meet the Minimum Training Requirements (see 2.2) in order for their training to be approved by the ANZTBCRS.

2.2. MINIMUM TRAINING REQUIREMENTS

2.2.1. FRACS

Trainees must already have attained a Fellowship of the Royal Australasian College of Surgeons (FRACS).

2.2.2. Curriculum

The following is a list of anatomy, physiology, radiology, investigative procedures and disease processes that the trainee will cover during the 2 years of training.

Upon completion of training the trainee will understand:

- The pathophysiology, presentation and natural history of disorders of the colon, rectum, anus and small bowel.
- The investigative procedures available to efficiently diagnose diseases involving the colon, rectum, anus and small bowel.
- The treatment options available for these diseases involving the colon, rectum, anus and small bowel, including the risks and benefits of the operative and non-operative procedures.

- The pre, intra-, and postoperative management of diseases involving the colon, rectum, anus and small bowel, including the management of complications of therapy.

See SECTION 4 for a list of topics included in the curriculum.

2.2.3. Syllabus

There are no prescribed texts. Recommended reading includes:

- The ASCRS Textbook of Colon and Rectal Surgery. Third edition. 2016. Springer
- Surgery of the Anus, Rectum and Colon (2 volume set). Keighley MRB and Williams NS. 2018, Fourth edition. Elsevier Health Sciences
- Current Therapy in Colorectal Surgery. Fazio VW, Church JM, Delaney CP. Third edition. 2016.
- Colorectal Surgery: A Companion to Specialist Surgical Practice. Sue Clark. 2018. 6th edition. Saunders Book Company
- Clinical practice guidelines for the prevention, early detection and management of colorectal cancer
- Clinical Practice Guidelines for Surveillance Colonoscopy
- ANZTBCRS Training Weekend papers (Current year and Previous 2 years)
- Diseases of Colon & Rectum.

2.2.4. Trainee Evaluation

Assessment is continuous.

The ANZTBCRS Evaluation Form is designed to allow a Training Unit to evaluate the performance of their ANZTBCRS Trainee, to identify any areas requiring remediation or extra training and, with the assistance of ANZTBCRS, put structures in place to enable the Trainee to successfully complete the training year.

Details on usage of the form can be found on the website.

The form is to be completed by the Training Unit twice a year:

- A mid-year Evaluation due at the CSSANZ Office by close of business on the last working day of June, and,
- An end of year Evaluation due at the CSSANZ Office by close of business on the last working day of February.

The Program Director must have a performance assessment meeting with the Trainee to discuss the Evaluation report. Following this meeting the signed form is to be emailed to the CSSANZ Office for ratification by the Training Board.

If a Training Unit has concerns about a Trainee's performance, these concerns should be forwarded to ANZTBCRS via the CSSANZ Office as soon as possible.

Please also read Section 2: Policies on Assessment of Clinical Training and Dismissal from Post Fellowship Colorectal Training.

2.2.5. Journal Club

Attendance at local Journal Club Meetings is an essential and compulsory part of training and a trainee's contribution at these meetings is very important.

Details of local Journal Club meetings can be found on the Journal Club page in the Members' Section of the CSSANZ website. The Journal Club articles will be emailed prior to each meeting. It is expected that Trainees will attend most of the meetings each year.

2.2.6. Interviews

To ensure the standards of training are being met and to receive feedback, the ANZTBCRS requires each trainee to attend one face to face interview during the year. (Trainees in units outside of Australia and New Zealand are not expected to return for an interview.) These interviews will coincide with the ASC and the CME. First year trainees are encouraged to attend the interviews at the ASC so that research projects and other issues can be discussed.

2.2.7. Logbooks and Procedure Based Assessments

2.2.7.1. LOGBOOKS

ANZTBCRS trainees are to use the RACS MALT logbook to record operative cases.

Vital information regarding MALT and ANZTBCRS usage of this tool can be found on the College website under Information for ANZTBCRS. Please review this page prior to using the system for the first time.

An Excel logbook can be downloaded via the Forms menu on the Training page of the CSSANZ website. It is envisaged that this will only be needed for those in overseas posts when MALT cannot be used.

Logbook data (including supervisor approval) must be completely up to date by 30 April, 30 September, and at the end of a trainee's clinical year, with the last date for entry/approval: 28 February.

MALT logbook summaries will be accessible by the ANZTBCRS at the face to face interviews, so trainees are required to ensure that their supervisor has approved all cases prior to their interview and that the logbook is up-to-date (by the above dates).

If there are any concerns about how to complete the logbook correctly, trainees should speak to their Program Director or any member of the ANZTBCRS. The ANZTBCRS uses the Logbook to assess a trainee's overall operative and colonoscopy workload, with particular emphasis on ensuring appropriate degree of supervision.

The Board will expect that trainees will meet or exceed the minimum number of cases each year (see 4.4.13).

2.2.7.2. PROCEDURE BASED QUALITATIVE ASSESSMENTS

Procedure Based Assessments (PBAs) are an objective assessment of the trainee's adequacy of technical skills in a group of specific operations. It is a formalised process for discussing the individual components of each operation immediately following the completion of the procedure. Trainees are expected to complete PBAs for specified operation types in both their first and second years. The specific operations differ between the two years. The PBAs form part of the trainee's assessments, but also act to encourage a constructive and detailed learning exercise.

Each trainee will be responsible for submitting standardised Procedure Based Qualitative Assessment (PBA) forms, completed by a consultant, who must be a CSSANZ member (except in units outside of Australia and New Zealand). The forms must be completed and signed at the time of the procedure.

The trainee should attain a score of 3 to pass a PBA. If the score is lower in any component, then the PBA should be repeated until a satisfactory score is attained in all

components. The trainee should plan the timing of the PBA so that a repeat would be possible.

The assessment will be a part of the completion of their logbook assessment. All forms need to be submitted by the time that the end of year logbook is due for the training year to be deemed to have been successfully completed.

Details of the specific operations and PBA requirements can be downloaded via the Forms page on the website.

2.2.8. Training Weekend

All Trainees (in Australia and New Zealand) are expected to attend the Training Weekend as a compulsory component of training.

The meeting commences at lunchtime on Friday and concludes early Sunday afternoon. Travel arrangements will be organised for all attendees. The Training Weekend format is intense and is not designed for partners to attend.

All trainees receive a topic for presentation and are required to submit a written paper on that topic as well as presenting on this topic at the Training Weekend. The papers for the weekend are published on the CSSANZ website (Members' area, "Training Board" page) as education for all members of CSSANZ.

The Program Director (or their delegate) will be the co-author of the document for publication and it is important that the trainee liaise with them about this paper.

The best presentation at the Training Weekend will be selected for the Philip Douglas Education Prize. The winner will then re-present their paper during the CME meeting (or equivalent) that year.

All Trainees will be expected to make a brief presentation and accept questions on their research progress at the Training Weekend.

In addition, there are three prizes for research presentations:

- CSSANZ Foundation Award for the Most Promising Research Project (first year trainee)
- CSSANZ Foundation Award for the Most Publishable Completed Research Project (second year trainee)
- CSSANZ Foundation Award for Research arising from a Higher degree.

See Awards/Scholarships and Fellowships for more details about these awards.

2.2.9. Annual Examination

First years are not required to sit the exam so that they are able to focus heavily on their research project in their first year. The exam is an exit exam for second years only.

It will be held in October. The repeat examination date if necessary will be in December.

The exam will be a two-hour written examination comprising 10 questions and will be held in the trainee's current city of training. The exam is designed to encourage and assess a reading curriculum rather than operative and clinical care which is assessed by the logbooks, the procedure based assessments and Evaluation Forms which are provided by the Program Director to the ANZTBCRS.

The curriculum for the examination is:

a) Clinical practice guidelines for the prevention, early detection and management of colorectal cancer (as approved by the Australian Government's National Health and Medical Research Council in October 2017);

b) Clinical Practice Guidelines for Surveillance Colonoscopy

c) ANZTBCRS Training Weekend papers - current year of exam and previous 2 years;

d) Diseases of Colon & Rectum^ - July (year prior to taking exam) – June (year of exam).

The aim of the syllabus is for ongoing reading from DAY 1.

Past exam papers and Training Weekend papers can be found on the “Training Board” page in the Members’ area of the CSSANZ website.

ANZTBCRS Assessment – Marking Range:

Marking range	Outcome
2-3	Outright FAIL
4-5	Borderline Fail/Pass
6-7	Outright Pass
8-9	Credit – Distinction

ANZTBCRS Assessment – Pass Criteria:

To pass the exam the candidate MUST fulfill all 3 criteria:	
1	Total Mark > 50
2	Not receive 4 or less in 4 questions
3	Not receive 5 or less in 5 questions

^DCR Online Access: Trainees will be given access to DCR in their clinical (and research) years. The access code for Diseases of Colon and Rectum Journal (DCR) will be sent to new Trainees early in the year. DCR online can also be accessed free of charge via the College library.

2.2.10. Research

Each Trainee must prepare a scientific paper for podium presentation and publication in a peer reviewed journal. Preliminary discussions must occur with Program Director and/or Head of Unit well before commencing first year so that the project can commence as soon as possible.

First years need to focus heavily on their research project in their first year.

First year Trainees are required to submit details of their proposed research protocol to the Research Support Committee by February and provide an update by 30 June.

This update should include details of the current status of the project and proposed abstract submission and publication.

At the end of the year, a further update of position and status of project protocol will be required.

Appropriate progression with the research project is an important component of the ANZTBCRS assessment and will be a factor when determining choice of placement for the second year of colorectal post-fellowship training.

Second year Trainees are expected to provide similar progress updates (at 30 June and EOY) and to include details of abstract and publication submission.

2.2.11. Training Completion Requirements

Training is not completed until:

1) Assessment Forms (Evaluation Reports, PBAs) have been received and accepted by the ANZTBCRS.
2) Trainee's logbooks and PBA forms have been reviewed and accepted by the ANZTBCRS.
3) Evidence is presented by the Trainee of a publication*, either published or accepted for publication in a peer reviewed journal, and a podium presentation[##], or forthcoming podium presentation, of a paper to an appropriate meeting[#].
4) The ANZTBCRS exam has been passed.
5) An Exit Interview has been taken and the ANZTBCRS has reviewed and signed off on all criteria. (See 2.2.13)

*Publication. The publication can be: results of research undertaken whilst a Trainee; a chapter in a book; or an appropriate prospectively performed and awarded MS or PhD incorporating research which was at least partially undertaken whilst a trainee. Preferably, the trainee should be first author. If the trainee is a 2nd author, the trainee would need to present a written summary detailing their involvement in the publication. This summary would be reviewed by the ANZTBCRS and, if considered acceptable, the publication would then be approved as meeting ANZTBCRS requirements.

[#] Meetings which are acceptable for presentation: International, National, or State RACS.

[##] A poster presentation (with/without a talk) does NOT qualify for the ANZTBCRS presentation requirement.

2.2.12. Maximum Period for Training

There is a maximum period of three years from the end of the last program year recognised by the ANZTBCRS (see 2.1) in which to achieve training sign off (see 2.2.13). Trainees in this category ("Training Incomplete") will continue to pay an annual fee as per the ANZTBCRS schedule of fees. If a trainee does not achieve training sign off during this three-year period, their records will be marked "incomplete" and removed from the ANZTBCRS list. Their training will not be able to be signed off by the ANZTBCRS once this occurs.

2.2.13. Sign Off/ Certification

At the completion of the Program, the ANZTBCRS will review the training and a final ("Exit") interview will be conducted. Successful completion of the Program will be indicated when all criteria (see 2.2.11) has been met and sign off has been approved by the ANZTBCRS. A Certificate signed by the Chair Section, the President CSSANZ and the Chair ANZTBCRS, will be issued following sign off.

2.2.14. Annual Fee for Training

Annual Fees are payable in accordance with the published schedule.

Invoices will be issued in the first quarter of the year and payment is due in 30 days unless otherwise formally approved by the ANZTBCRS.

3. APPLICATION FOR ADMISSION TO THE ANZTBCRS TRAINING PROGRAM

3.1. OVERVIEW

3.1.1. The applicant must have satisfactorily completed the FRACS examination in general surgery.

3.1.2. All shortlisted applicants will be interviewed by a Selection Panel, appointed by the ANZTBCRS, before selection into the program.

3.1.3. The Selection Panel will be the members of the ANZTBCRS and any person(s) co-opted as required.

3.1.4. All shortlisted applicants will be interviewed, assessed and ranked by the Selection Panel. If required the Chair of the ANZTBCRS will have a casting vote.

3.1.5. The number of available clinical positions for any forthcoming year will be notified to the applicants at the time of interview.

3.1.6. Successful applicants will be allocated to training positions by the ANZTBCRS, and where possible, trainees will be placed according to their preference of available clinical units.

3.1.7. An unsuccessful applicant will be notified by the Chair of the ANZTBCRS.

3.1.8. Successful applicants will be notified of their hospital posting as soon as practical.

3.1.9. A maximum of 4 research positions will be available each year.

3.1.10. The maximum number of positions allocated per year (including 4 research positions) will be at the discretion of Training Board but unlikely to be more than half the number of accredited units.

3.1.11. It is not possible to commence a PhD during the first year of training. If a trainee is selected to do research during the first year of training, then this can be used to complete a PhD (final year) or to undertake a single year of a higher degree such as a Masters of Surgery.

3.2. APPLICATION REQUIREMENTS

3.2.1. Application

3.2.1.1. Application Form and FRACS Evidence

Applicants must email the following information, by the closing date, to admin@cssanz.org :

- A completed ANZTBCRS Application Template, and,
- Evidence of FRACS (a copy of your FRACS Certificate/Letter, or, if not yet attained, details of when you will be sitting the Part II exam).

3.2.1.2. Application Fee

Following the receipt of an application, an invoice will be issued to the applicant. The invoice must be paid before the application will progress.

3.2.1.3. Opening and Closing dates for Application

The opening and closing dates will be advertised via RACS Surgical News/Fax Mentis and on the CSSANZ website. Applications are to be sent to the email address above between 1 April and 1 May of the year before training commences.

3.2.2. Principal Referee

It is the aim of the Training Program that successful trainees will practice in the field of colon and rectal surgery, and that the Principal Referee, when nominated will act as a mentor, in both assisting in the organisation of training, and importantly, in assisting the trainee to establish themselves in their future career within colon and rectal surgery.

The nomination of the Principal Referee is not an absolute requirement and applications will be considered without prejudice in the absence of a nominated Principal Referee.

3.2.3. Referees

Referee reports will be requested on an applicant's behalf as soon as possible after an application is received. These reports must be received by 1 June or will not be considered. Applicants will need to ensure that their chosen referees are able to submit the reference by 1 June and are aware of the importance of doing so.

3.2.4. Selection

Members of the ANZTBCRS, and co-opted persons as deemed appropriate, will comprise the selection panel for the Program.

The selection panel will review and shortlist the applications by 14 June. Applicants will be notified during the week following this as to whether they have been shortlisted for interview.

Interviews will be held late July. All applicants will be notified of the results of their application, in writing, by the Chair, ANZTBCRS.

The ANZTBCRS will recommend appointments of successful applicants to the Units to which they have been selected. The Trainee will be employed by that hospital.

Please refer to the ANZTBCRS Selection Process document for more information.

4. GUIDELINES TO FACILITATE THE DEVELOPMENT OF A HOSPITAL BASED COLORECTAL SURGERY UNIT

4.1. PREAMBLE

The items covered in these guidelines have been deliberately broad so as to cover as many of the possible scenarios that may exist in a hospital based Colorectal Surgery Unit.

Definitions have been combined with specifications for the interest of simplicity, which provide the basis for minimum standards.

4.2. SURGICAL AND RELATED STAFF

A Colorectal Surgery Unit would be defined as a clinical team of at least two, but preferably three, surgeons plus related staff.

4.2.1. Surgeons

The Unit should consist of a Unit Head and at least one other surgeon with the following specifications:

4.2.1.1. FRACS

4.2.1.2. Postgraduate colorectal surgery training, either within Australia/New Zealand and overseas

4.2.1.3. Postgraduate qualification or a Certificate of Training (or its equivalent) in one or more of the following:

4.2.1.3.1. Colonoscopy

4.2.1.3.2. Anorectal Physiology

4.2.1.3.3. Endorectal Ultrasound

4.2.1.3.4. Surgical Oncology

4.2.1.3.5. Postgraduate Research Degree/Diploma

4.2.1.3.6. Other Postgraduate Qualification eg. management, epidemiology

4.2.1.4. Member of the Colon and Rectal Surgery Section of the Royal Australasian College of Surgeons and Ordinary Member or Fellow of the Colorectal Surgical Society of Australia and New Zealand.

4.2.1.5. Practices either exclusively colorectal surgery at this hospital or as a gastrointestinal surgeon where 80% of the patients managed are in colorectal surgery in this hospital.

4.2.2. Other Medical Staff

The Unit shall have allocated to it:

4.2.2.1. An Advanced Trainee in General Surgery or its equivalent and/or a Colorectal Fellow.

4.2.2.2. An HMO as either an intern (PGY1) or more senior (PGY2 or 3) dedicated to the Unit.

4.2.3. Stomal Therapist

The hospital shall have an appropriately qualified Stomal Therapist, if not full-time, at least on a regular basis to provide counselling and follow-up.

4.2.4. Nurse Unit Manager & Staff

The Colorectal Unit should have access to one ward, or part thereof, to serve the majority of the patients admitted to that Unit. Some of the nursing staff on this ward should have a specific interest in colorectal surgery. Ideally, the ward should be shared with the Gastroenterology Unit and/or Gastrointestinal Surgery Units of the hospital.

4.2.5. Ancillary Staff

The Unit should have available, other allied health professionals to provide a spectrum of care (for example physiotherapy, occupational therapy and medical social worker, pastoral care and liaison psychiatry).

4.3. THE HOSPITAL AND SUPPORTIVE SERVICES

To support a Colorectal Surgery Unit, the hospital involved should be equivalent size to, at least, a 300 bed metropolitan teaching hospital with availability of the following services:

4.3.1. Laboratory and Anatomical Pathology with a 24 hour frozen section service.

4.3.2. Intensive Care Unit and/or High Dependency Unit with the capacity to manage epidural anaesthesia.

4.3.3. Operating Theatres with a fully staffed recovery room.

4.3.4. Anaesthetic Department with at least one member of the anaesthetic staff with a particular interest in gastrointestinal surgery, pain management and regional anaesthesia.

4.3.5. Operating theatre nursing and technical staff with at least one team with a specific interest in Gastrointestinal Surgery and facilities for advanced laparoscopic surgery.

4.3.6. A purpose built independent Endoscopy Suite or an Endoscopy Suite incorporated in the Operating Theatre with a dedicated Nurse Unit Manager and back-up staff.

4.3.7. Ancillary colorectal investigation office space and supportive staff available to conduct Endorectal Ultrasound and/or Anorectal Manometry.

4.3.8. Accident and Emergency Department adequately staffed and with equipment to perform emergency rigid endoscopy.

4.3.9. Radiological sciences and an accredited imaging department with facilities for x-ray screening, CT scan, Visceral Angiography and Scintillation Scan.

4.3.10. Oncology and Radiotherapy access either within the hospital, or region for ambulatory care or inpatient radiotherapy and chemotherapy. Specifically the availability of an inpatient consultative service in medical oncology and radiotherapy.

4.4. SPECIFICATIONS AND FUNCTION OF THE COLORECTAL SURGERY UNIT

4.4.1. Day Surgery

The hospital should have access to a Day Surgery facility.

4.4.2. Operating

Each surgeon should have, at least, one half day operating per week dedicated to colorectal surgery.

4.4.3. Pre-admission Process

The Unit should have access to a pre-admission clinic or similar arrangement to assess elective surgical patients to facilitate same day surgical admissions.

4.4.4. Outpatient or Private Office Assessment

The Unit should have a dedicated outpatient clinic, with appropriate equipment for minor procedures or for surgeons to assess patients in a private office with similar equipment. Ideally, the surgeons of the Unit will attend the same outpatient clinic or share private office facilities.

4.4.5. After Hours Cover

The Unit should provide an exclusive or consultative on-call service 24 hours a day, 7 days a week for Accident & Emergency and inpatient emergencies.

4.4.6. Weekly Ward Rounds and Meetings

The Unit shall meet on a weekly basis to conduct meetings to discuss the patients, protocols or any other business combined at some stage with a visit to the patients (ward round).

4.4.7. Quality Assurance and Audit

The Unit should be involved in a regular mortality and morbidity meeting, at least on a monthly basis with a six monthly or annual review, and establish a Colorectal Surgery Database (see 4.4.12). Quality assurance programs (for example Clinical Indicators or quality projects) should become standard and reviewed at the weekly Unit meetings or audit meetings.

4.4.8. Research

The Unit shall have an interest in research either by encouraging individual research projects within the hospital or collaborating with existing clinical research projects.

4.4.9. Academic Affiliation

The Unit should have an affiliation with one of the University Medical Schools and be involved in Undergraduate Teaching Programs.

4.4.10. Basic and Advanced Training in General/Colorectal Surgery

Members of the Unit should be involved with the RACS activities to encourage surgical trainees in basic and advanced training in General and Colorectal Surgery. The Unit should also encourage overseas trainees or colorectal surgeons to visit the Unit.

4.4.11. CPD, Recertification and Office Environment

The Unit head should be responsible for ensuring that the Guidelines provided by the Colon and Rectal Surgery Section of the Royal Australasian College of Surgeons and the Colorectal Surgical Society of Australia and New Zealand are fulfilled and that all members participate in CPD activities. In addition, the Unit should provide adequate office space for the trainee to be able to work.

4.4.12. Bi-National Colorectal Cancer Audit Participation

All ANZTBCRS units will be expected to contribute their data to Bi-National Colorectal Cancer Audit (BCCA). All core surgeons in a unit should be contributing to BCCA and each unit must have their unit procedures set up, so that when their trainee commences in January, they are able to take on this task immediately.

4.4.13. Minimum number of cases for Fellows

The Board has developed guidelines on minimum numbers for each unit. The Trainee's logbook would need to meet these number as a minimum each year.

4.4.14. On Call

The Training Board expects that the Trainee will have at least two weekends per month completely rostered off.

5. ACCREDITATION OF RESEARCH FELLOWSHIP IN COLORECTAL SURGERY

5.1. OBJECTIVES

To offer training in research methodology, either basic or clinical, in the area of colorectal surgery to colorectal Trainees in accredited Australian or New Zealand colorectal research units.

To accept a maximum of 12 months accreditation towards the Australian and New Zealand Colorectal Training Program. This is in addition to the two years of clinical training and does not replace one clinical year.

The objectives complement the documented objectives of ANZTBCRS.

5.2. CONDITIONS OF APPROVAL

To have one year of research approved by the ANZTBCRS as a recognised year of the training program, the following apply:

5.2.1. Prerequisites

5.2.1.1. Approval must be sought prospectively through application to the ANZTBCRS.

5.2.1.2. Trainee must fulfil documented prerequisites of the ANZTBCRS for training in colorectal surgery.

5.2.1.3. Research fellowship must be linked to an ANZTBCRS accredited colorectal unit.

5.2.1.4. Project must be approved by ANZTBCRS as appropriate to colorectal surgical training.

5.2.1.5. Final outcome review of research project by ANZTBCRS.

5.2.1.6. Research fellowship year

a) If it occurs during the first year of ANZTBCRS fellowship and preceding the clinical year(s), must be at a different unit to the clinical fellowship years.

b) If it is following successful completion of the clinical fellowship year(s), may be at the same unit as the preceding clinical fellowship year following application by the Trainee for such approval and upon review and approval by the ANZTBCRS. Otherwise, the research fellowship year must be at a different unit to the clinical fellowship years.

5.2.2. Prospective Approval

Approval for accreditation must be sought the year prior to commencing the research fellowship with a combined application to the ANZTBCRS by the Trainee and the supervisor of the research fellowship from an accredited colorectal unit.

5.2.3. Trainee Approval

5.2.3.1. Accepted by the ANZTBCRS as colorectal post fellowship Trainee.

5.2.3.2. Enrolled in an ANZTBCRS approved higher degree (Masters, PhD, MD) and that higher degree must include a research component.

5.2.4. Accredited Colorectal Research Unit

5.2.4.1. ANZTBCRS accredited (or approved) colorectal unit for clinical fellowship training. Attendance at weekly clinical colorectal meetings and colorectal journal clubs.

5.2.4.2. University affiliation for enrolment in Masters or PhD.

5.2.4.3. Funded research position.

5.2.4.4. Adequate unit research infrastructure, including ongoing projects, past research track record, infrastructure funding to support incidentals and statistician.

5.2.4.5. Supervisor of research training

5.2.5. Approved Project

5.2.5.1. Submission of research project under NH & MRC grant guidelines to ANZTBCRS for consideration of research scholarship.

5.2.5.2. Project suitable for post-graduate degree.

5.2.5.3. Fully funded project.

5.2.5.4. Colorectal surgeon as at least one thesis supervisor of project.

5.2.6. Final Outcome Review

5.2.6.1. Report from supervisor of research training to ANZTBCRS attesting to a successful research year.

5.2.6.2. Report from colorectal surgeon as thesis supervisor at completion to ANZTBCRS.

5.2.6.3. Report from trainee including progress during the year, publication and presentation emanating from project.

SECTION 2: POLICIES

1. ASSESSMENT OF CLINICAL TRAINING

1.1. PURPOSE AND SCOPE

This policy outlines the assessment of a Trainee undertaking clinical training in an accredited training position as part of the Colorectal Post Fellowship Training Program which is administered by the ANZTBCRS.

Colorectal post fellowship training is designed to provide Trainees with clinical and operative experience that produces independent specialist colorectal surgeons.

1.2. BODY OF POLICY

1.2.1. Assessment of Performance during Clinical Training

1.2.1.1. Each accredited training position has a Program Director nominated by the hospital and approved by the ANZTBCRS. Program Directors coordinate, and are responsible for, the management, education, training and assessment of post fellowship colorectal Trainees rotating through their designated accredited training posts.

1.2.1.2. Trainers are surgeons who normally interact with the Trainees in the operating theatre, outpatient department and during clinical meetings and education sessions. Trainers may assist the Program Director with monitoring, guiding and giving feedback to the Trainees, as well as appraising and assessing their performance.

1.2.1.3. The assessment of a Trainee's performance by the Program Director is fundamental to their continuing satisfactory progression through the colorectal program. Constructive feedback from the consultant team to the ANZTBCRS Trainee is an essential component of the post Fellowship training program. It is expected that all surgeons provide informal feedback on a regular basis and that a more formal process is in place with the designated Program Director meeting with the Trainee at least monthly.

1.2.1.4. The ANZTBCRS Evaluation Form is designed to allow a Training Unit to evaluate the performance of their ANZTBCRS Trainee, to identify any areas requiring remediation or extra training and, with the assistance of ANZTBCRS, put structures in place to enable the Trainee to successfully complete the training year.

1.2.1.5. The form is to be completed by the Training Unit twice a year:

- A mid-year Evaluation due at the CSSANZ Office by close of business on the last working day of June, and
- An end of year Evaluation due at the CSSANZ Office by close of business on the last working day of February, or,

  as soon as is practicable any time after the identification of unsatisfactory or marginal performance as determined by the Program Director (see also 1.2.3).

The Program Director must have a performance assessment meeting with the Trainee to discuss the Evaluation report. Following this meeting the signed form is to be emailed to the CSSANZ Office for ratification by the Training Board.

1.2.1.6. The completed assessment report should be signed and dated by both the Trainee and the Program Director and should reflect the discussions held during the applicable performance assessment meeting. Signing the assessment report confirms the assessment report has been discussed but does not signify agreement with the assessment.

1.2.1.7. The Trainee is responsible for forwarding the completed assessment report to the ANZTBCRS by the communicated due date or within one week of signing of the assessment report, whichever is sooner.

1.2.1.8. Trainees are required to keep a copy of the assessment report for their personal records and training portfolio.

1.2.1.9. The ANZTBCRS is responsible for the review of assessment report and accreditation of clinical rotation (also see 1.2.4).

1.2.2. Assessment of Operative Experience during Clinical Training

1.2.2.1. Accurate reporting of the operative experience by each Trainee in an accredited clinical training position is required. The operative logbook provides details about the Trainee's level of supervised and independent surgical operative experience.

1.2.2.1.1. LOGBOOKS

Each trainee is required to record their operative experience accurately using the MALT logbook.

MALT Logbook data (including Program Director approval) must be completely up to date by 30 April, 30 Sept, and at the end of the clinical year by 28 February of the following year.

1.2.2.1.2. PROCEDURE BASED ASSESSMENTS

Each trainee is required to complete and record the four specified Procedure Based Assessments annually - once at the end of first year and once at the end of second year.

Each trainee will be responsible for submitting the standardised PBA forms completed by the CSSANZ consultant (for ANZTBCRS units) at that operation along with their logbook. The PBA assessment will be a part of the completion of their logbook assessment.

1.2.2.2. The ANZTBCRS is responsible for the review of logbooks, procedure based assessments and accreditation of clinical rotation.

1.2.2.3. Inaccurate recording of procedures in the operative logbook or PBA is classified as misconduct and forms grounds for dismissal in accordance with the ANZTBCRS Dismissal from Post Fellowship Colorectal Training Policy.

1.2.3. Probationary Status for Unsatisfactory or Marginal Performance

1.2.3.1. If a Training Unit has concerns about a Trainee's performance that need to be addressed, these concerns should be forwarded to ANZTBCRS via the CSSANZ Office as soon as possible.

A borderline score (3 or 4) in any of the assessment parameters on the Evaluation Form will lead to a telephone conversation between the ANZTBCRS and the Program Director to decide if a probationary plan would be appropriate and/or beneficial.

An unsatisfactory overall assessment or an unsatisfactory score (1 or 2) in any of the assessment parameters on the Evaluation Form will lead to a face to face meeting involving the Trainee, the Program Director and a member of ANZTBCRS. A

probationary plan, which must be followed successfully for the training year to be counted towards completion of the ANZTBCRS program, will be put in place at this meeting. Documentation to be used for this period: Probation Documentation Form, Probation Evaluation Form.

1.2.3.2. The plan will include:

a) Identification of the areas of unsatisfactory or marginal performance;

b) Confirmation of the remedial action plan;

c) Identification of the required standard of performance to be achieved;

d) Notification of the duration of the probationary period;

e) The frequency at which assessment reports must be submitted;

f) Possible implications if the required standard of performance is not achieved.

1.2.3.3. The probationary period should usually be no less than three months.

1.2.3.4. During the probationary period the Trainee's performance should be regularly reviewed by the Program Director and the Trainee should be offered constructive feedback and support.

1.2.3.5. If performance has improved to the required standard at the conclusion of the probationary period, then, with the agreement of all three parties, the probationary status must be removed.

1.2.3.6. If the trainee has failed the probation, this will be reflected in an overall Unsatisfactory result on the Probation Evaluation Form. Should this be the case, probation will continue under the same terms for the remainder of the training year.

1.2.3.7. The probation period should be considered as separate to the overall assessment of the Trainee at the end of the Training year. It is designed to help the Trainee to recognise and work to correct their deficiencies and (hopefully) to turn an unsatisfactory mid-year evaluation (or early concerns raised by the Unit) into a satisfactory end of year evaluation. However, whilst the results of probation may inform the Unit's final evaluation, it is important that all parties are aware that the end of year assessment is a separate and formal process. The Unit should be assessing the whole year when the final assessment is made.

1.2.3.8. A failed probation does not exclude a pass at the end of year assessment.

1.2.3.9. A passed probation does not guarantee a pass at the end of year assessment.

1.2.3.10. If performance has not improved to the required standard at the conclusion of the year or second probationary period, then the Trainee will fail this year of training and ANZTBCRS has the option to dismiss Trainee in accordance with the ANZTBCRS Dismissal from Post Fellowship Colorectal Training Policy or to offer another appointment to repeat this year.

1.2.4. Accreditation of Clinical Training Placements

1.2.4.1. A 12-month clinical rotation will be recorded as satisfactory when the assessment reports, logbooks and PBAs have been submitted by the communicated due date and satisfy the ANZTBCRS performance standards.

1.2.4.2. A 12-month clinical rotation will be recorded as unsatisfactory when an assessment report or logbook is not submitted by the due date or in accordance with instructions from the ANZTBCRS.

1.2.4.3. A 12-month clinical rotation will be recorded as unsatisfactory when an assessment report or logbook does not satisfy the ANZTBCRS performance standards.

1.2.4.4. A 12-month clinical rotation may be recorded as unsatisfactory if leave exceeds six weeks.

1.2.4.5. Where an assessment report is rated as marginal the ANZTBCRS must review the report and determine if the clinical rotation is to be recorded as unsatisfactory (see 1.2.3).

1.2.5. Appeal

Decisions relating to clinical assessment may be reviewed or appealed in accordance with the ANZTBCRS Appeals Mechanism Policy.

2. DISMISSAL FROM POST FELLOWSHIP COLORECTAL TRAINING

2.1. PURPOSE AND SCOPE

It is the policy of the ANZTBCRS that all disciplinary and dismissal matters be dealt with fairly, promptly, and in such a manner as is consistent with the rules of natural justice. This policy relates to the principles of dismissal from the ANZTBCRS training program.

The ANZTBCRS is the body accredited to conduct colorectal surgical education and training in Australia and New Zealand and is the joint responsibility of the CSSANZ and the Section.

The ANZTBCRS is responsible for the assessment of overall performance and supervision of post fellowship colorectal Trainees. It is recognised the Section, the CSSANZ and the Trainee's employing body share responsibility for managing a Trainee's performance and that dismissal from Colorectal Post Fellowship Training may affect a Trainee's employment.

2.2. BODY OF POLICY

2.2.1. Unsatisfactory Performance

2.2.1.1. Trainees may be considered for dismissal for unsatisfactory performance if:

a) the Trainees' performance has been rated as unsatisfactory during a probationary period applied in accordance with the ANZTBCRS Assessment of Clinical Training Policy, or

b) the Trainees' performance has been rated as unsatisfactory for two or more six-month assessment periods at any time during their Colorectal Training Program.

2.2.1.2. If dismissal is considered applying 2.2.1.1.(b), the Trainee must have received written notification after the first unsatisfactory assessment period that any further unsatisfactory assessment period at any time during their Colorectal Training Program may result in dismissal.

2.2.1.3. A subcommittee of the ANZTBCRS must interview the Trainee prior to making a decision regarding dismissal to provide the Trainee with the opportunity to give their perspective in writing and verbally.

2.2.1.4. The subcommittee shall consist of at least 3 ordinary members from the ANZTBCRS. The subcommittee must not include a practicing lawyer.

2.2.1.5. No person invited to assist the subcommittee in matters of fact can appear before the subcommittee without the presence of the Trainee.

2.2.1.6. Where a Trainee elects to make a written submission, it should be submitted at least three (3) working days before the meeting.

2.2.1.7. Minutes of the meeting must be kept and the meeting recorded. The minutes must be provided to the Trainee within 10 working days and prior to any recommendation to the ANZTBCRS.

2.2.1.8. Trainees will be provided with a minimum of 10 working days' notice of the meeting and informed that the purpose of the meeting is to consider their continued participation in the training program. Trainees may be accompanied by a person who can provide support but cannot advocate for the Trainee. The support person cannot be a practicing lawyer.

2.2.1.9. Where a Trainee is duly notified of the meeting and declines to attend, the subcommittee may make a recommendation to the ANZTBCRS.

2.2.1.10. The recommendation and minutes of the subcommittee must be forwarded to the ANZTBCRS for consideration.

2.2.1.11. The ANZTBCRS will make the recommendation on whether or not the Trainee should be dismissed or any additional probationary periods or conditions that should be applied if dismissal is not recommended.

2.2.1.12. The ANZTBCRS must be satisfied that the recommendation can be substantiated and that the relevant processes have been followed and documented.

2.2.1.13. Where dismissal is recommended the Trainee may be suspended from training and the ANZTBCRS must seek ratification of the dismissal from the Executive of the Section and the Council of the CSSANZ who will review the decision-making process and substantiating documentation to ensure that due diligence and appropriate processes have been followed.

2.2.1.14. Substantiating documentation must demonstrate that the Trainee had appropriate meetings to discuss performance and had a performance management plan addressing known deficiencies.

2.2.1.15. The final dismissal letter must be issued to the Trainee under the signature of the Chair of the ANZTBCRS and the Chair of the Section and the President of the CSSANZ.

2.2.1.16. The employing authority should be kept informed throughout the process and be provided with the opportunity to contribute where necessary.

2.2.2. Dismissal for Misconduct

2.2.2.1. Examples of misconduct include but are not limited to the following:

a) Discrimination, harassment or bullying

b) Abusive, violent, threatening or obscene behaviour

c) Being found guilty of a criminal offence which results in a jail term or restrictions on the Trainee's ability to practice medicine

d) Theft, fraud or misappropriation of funds

e) Being under the influence of alcohol or illegal drugs while at work

f) Falsification of training records, patient documentation or patient treatment

g) Serious breach of patient safety

h) Gross insubordination or wilful disobedience in carrying out lawful requirements of the Training Program

i) Bringing the CSSANZ's or the College's name into disrepute

j) Abandonment of employment or training post

k) Dishonesty

l) Academic misconduct (refer to Section 3 - Glossary: Academic Misconduct Definition)

2.2.2.2. Incidents of misconduct must be documented and verified as soon as possible after the supervisor and/or trainers are made aware of their occurrence and brought to the attention of the Trainee. Allegations of misconduct not documented and verified cannot be used by the ANZTBCRS in any disciplinary process.

2.2.2.3. The principles of natural justice will apply to all allegations and investigations concerning misconduct. This includes the right of the Trainee to understand, consider

and respond to the alleged misconduct at a meeting with a subcommittee of the ANZTBCRS. The Trainee may be suspended from the training program pending an investigation.

2.2.2.4. The subcommittee shall consist of a minimum of 3 and a maximum of 5 members who shall be Fellows of the College and members of the ANZTBCRS. The subcommittee must not include a practicing lawyer.

2.2.2.5. No person invited to assist the subcommittee in matters of fact can appear before the subcommittee without the presence of the Trainee.

2.2.2.6. Trainees will be provided with a minimum of 10 working days' notice of the meeting and informed that the purpose of the meeting is to consider their continued participation in the training program. All documentation pertinent to the allegation must be provided at this time. Trainees may be accompanied by a person who can provide support but cannot advocate for the Trainee. The support person cannot be a practicing lawyer.

2.2.2.7. Where a Trainee elects to make a written submission, it should be submitted at least three (3) working days before the meeting.

2.2.2.8. Minutes of the meeting must be kept and the meeting recorded. The minutes must be provided to the Trainee within 10 working days and prior to any recommendation to the ANZTBCRS.

2.2.2.9. The recommendation and minutes of the subcommittee must be forwarded to the ANZTBCRS for consideration.

2.2.2.10. A Trainee may be dismissed for misconduct without undertaking a probationary period. Where misconduct is established but dismissal is not recommended the Trainee may be counselled and given a probationary period in which to improve their behaviour.

2.2.2.11. The ANZTBCRS will make the recommendation on whether or not the Trainee should be dismissed or any additional probationary periods or conditions that should be applied if dismissal is not recommended.

2.2.2.12. In all misconduct instances where dismissal is recommended, the ANZTBCRS must seek ratification from the Section Executive and the CSSANZ Council. Substantiating documentation must detail the misconduct and the reasons for recommending dismissal and demonstrate that the Trainee had appropriate meetings to discuss the allegations.

2.2.2.13. The Section Executive and the CSSANZ Council must be confident on review of the evidence that the misconduct justifies dismissal or summary dismissal, and that appropriate documentation and evidence is available to support such a decision.

2.2.2.14. The final dismissal letter must be issued to the Trainee under the signature of the Chair of the ANZTBCRS and the Chair of the Section and the President of the CSSANZ.

2.2.2.15. The employing authority should be kept informed throughout the process and be provided with the opportunity to contribute where necessary.

2.2.3. Failure to complete training program requirements

2.2.3.1. The Colorectal Training Program has specified minimum training requirements (refer to Section 1 – ANZTBCRS Regulations: Minimum Training Requirements) to be satisfied within timeframes determined by ANZTBCRS Regulations.

2.2.3.2. Trainees who fail to complete the training requirements within the timeframe specified by the ANZTBCRS may be required to repeat the year of training that was not completed satisfactorily or may be dismissed.

2.2.3.3. The ANZTBCRS will make the recommendation on whether or not the Trainee should be dismissed or any probationary periods or conditions that should be applied if dismissal is not recommended.

2.2.3.4. The ANZTBCRS must be satisfied that the recommendation can be substantiated and that the relevant processes have been followed and documented.

2.2.3.5. Where dismissal is recommended the Trainee may be suspended from training and the ANZTBCRS must seek ratification of the dismissal from the Executive of the Section and the Council of the CSSANZ who will review the decision-making process and substantiating documentation to ensure that due diligence and appropriate processes have been followed.

2.2.3.6. In all instances the final dismissal letter must be issued to the Trainee under the signature of the Chair of the ANZTBCRS and the Chair of the Section and the President of the CSSANZ.

2.2.4. Failure to comply with ANZTBCRS and or RACS Direction

2.2.4.1. Trainees are required to comply with any policy direction of the ANZTBCRS, RACS or its Agents pertaining to training activities.

2.2.4.2. Breaches of the RACS Code of Conduct that are not misconduct (refer to 2.2.2) are considered to be a failure to comply with RACS direction.

2.2.4.3. Repeated failure to comply with directions during the life of the training program will constitute a dismissible offence.

2.2.4.4. Trainees will receive written warnings, the second of which will advise that any further breach during the life of the training program may result in dismissal.

2.2.5. Failure to pay outstanding monies

Trainees who do not pay outstanding monies owed to the ANZTBCRS will be dismissed in accordance with the ANZTBCRS Credit Management Procedure.

2.2.6. Failure to satisfy medical registration or employment requirements

2.2.6.1. Trainees who, for any reason (excluding medical), do not have valid medical registration from the applicable Medical Board or Council in their jurisdiction that enables full participation in the training program will be dismissed.

2.2.6.2. Valid medical registration is defined as general medical registration without restriction in Australia, and general scope registration (including restricted general scope registration in the relevant specialty) in New Zealand.

2.2.6.3. Trainees who fail to satisfy the employment requirements of the institution in which their allocated training position is located (as notified by the CEO or HR Director or equivalent) may be automatically suspended from the training program.

2.2.6.4. Where employment is refused, the Trainee must be informed within 10 working days and provided with copies of the employer's correspondence to the ANZTBCRS.

2.2.6.5. After 30 working days of the date of notification to the Trainee of the second refusal of employment, dismissal proceedings may commence.

2.2.6.6. Trainees who fail to satisfy the employment requirements of two or more institutions in which allocated training positions are located will be dismissed.

2.2.6.7. The final dismissal letter must be issued to the Trainee under the signature of the Chair of the ANZTBCRS and the Chair of the Section and the President of the CSSANZ.

2.2.7. Appeal

Decision relating to dismissal from colorectal training may be appealed in accordance with the ANZTBCRS Appeals Mechanism Policy.

3. CREDIT MANAGEMENT PROCEDURE

3.1. PURPOSE AND SCOPE

Invoices for the ANZTBCRS Training Fees are issued by CSSANZ. This policy outlines invoice process, as well as the procedures and outcome for non-payment of any outstanding invoices.

3.2. BODY OF POLICY

3.2.1. Training Fees will be set and reviewed annually. Fees will be published on the CSSANZ website.

3.2.2. Fees will be invoiced in the first quarter of each year.

3.2.3. Payment terms will be 30 days.

3.2.3.1. Reasonable requests for a delayed payment or payment in instalments will be considered.

3.2.3.2. Requests for variation of terms must be submitted within 30 days of invoice.

3.2.4. Overdue invoices will be followed up and, if all reasonable encouragement for payment is not successful, then the Trainee will be considered in breach of the Minimum Training Requirements (see Section 1 – ANZTBCRS Regulations, Item 2.2.14).

3.2.4.1. A Trainee's year or training cannot be signed off if there are payments owing.

3.2.4.2. The Trainee will be given a final opportunity for payment.

3.2.4.3. Failure to meet this final opportunity will result in the Trainee being dismissed from the Training Program (Refer to ANZTBCRS Dismissal from Post Fellowship Colorectal Training Policy).

4. APPEALS MECHANISM

4.1. PURPOSE AND SCOPE

It is the policy of the ANZTBCRS that all matters be dealt with fairly, promptly, and in such a manner as is consistent with the rules of natural justice. This policy relates to the method to appeal a decision of dismissal from the ANZTBCRS training program or where a training year has been marked unsatisfactory.

The ANZTBCRS conducts post fellowship colorectal surgical education and training in Australia and New Zealand and is the joint responsibility of the CSSANZ and the Section.

The ANZTBCRS is responsible for the assessment of overall performance and supervision of post fellowship colorectal Trainees. It is recognised the Section, the CSSANZ and the Trainee's employing body share responsibility for managing a Trainee's performance and that dismissal from post fellowship colorectal training may affect a Trainee's employment.

4.2. BODY OF POLICY

The affected Trainee has the right to request the Chair of the ANZTBCRS to review a decision regarding dismissal from the Training Program or where a training year has been marked as unsatisfactory.

4.2.1. The Chair of the ANZTBCRS, the President CSSANZ and the Chair Section will select an Appeals Panel comprising suitably qualified medical practitioners who were not previously involved in the original decision process, to review relevant information, to conduct interviews and investigate as appropriate.

4.2.2. If there is a conflict of interest, an alternate representative will take the place of the person who has the conflict of interest.

4.2.3. The Appeals panel will act according to the rules of procedural fairness and decide each appeal on its merits. The Appeals panel is not bound by the rules of evidence and, subject to these rules and rules of procedural fairness, may inform itself on any matter and in such manner as it thinks fit.

4.2.4. The affected trainee may bring a support person or legal representative to the interview with the Appeals panel. Legal advisors (if any) and/or support persons may not act as advocate for the affected Trainee but may be invited to address the Appeals panel regarding any particular relevant issue.

4.2.5. A representative of the Training Board is expected to attend and address the Appeals panel on matters relevant to the appeal and will be given equal opportunity to comment.

4.2.6. The decision of the Appeals panel will be final.

5. OVERSEAS TRAINING AS PART OF THE ANZTBCRS TRAINING PROGRAM

5.1. PURPOSE AND SCOPE

Currently the ANZTBCRS Program requires a minimum of two clinical years in Accredited Australian and/or New Zealand Colorectal units, and may also involve one additional year in accredited full time research. It is possible to have one of the clinical years in a prospectively accredited overseas unit. The ANZTBCRS training units have all been formally accredited and are re-accredited at least every five years to maintain a minimum standard set by the Board. This accreditation involves a formal on-site inspection of the unit and hospital, a review or all services available to the trainee, a detailed review of recent past trainees' logbook numbers and a review of the research output from the unit.

In recent years there have been a number of trainees who have undertaken accredited training in overseas units where the training experience has been less than is expected from the Australian and New Zealand units. The specific concerns raised include: a) low overall and colorectal-specific log book numbers, and b) more of an emphasis on "service provision" rather than specialist-level active training. It is not feasible for the ANZTBCRS to put each potential overseas unit through the same accreditation process that is applied to the Australian and New Zealand units. The underlying concern is that ANZTBCRS trainees may return from overseas training without meeting the minimum requirements set out for training under the ANZTBCRS.

5.2. BODY OF POLICY

5.2.1. The ANZTBCRS will now require a more detailed and formal assessment of any overseas training position when an Accredited Trainee requests prospective accreditation as part of the two clinical years. This will not be identical to the current assessment of the Australian and New Zealand training units however will mirror many of the same requirements. It will be the Trainee's responsibility to provide all the necessary information in an appropriate timeframe to allow an overseas training unit to be prospectively accredited as part of their training.

5.2.2. The ANZTBCRS will require:

a) An application letter outlining the reasons the Trainee is requesting overseas training rather than training in an ANZTBCRS unit. This should include a detailed explanation of what they expect to learn in that particular unit, what their training has involved up to that point in time, and how they see the proposed overseas training benefitting their long-term surgical practice.

b) A signed letter of appointment or agreement to appoint from the overseas unit, including the planned start and finish dates.

c) A detailed weekly schedule outlining the Trainee's activities and responsibilities while in the overseas job. If this is an existing job being filed by another trainee currently, then a copy of the existing schedule, or if this is a new job, then a clear schedule of what the Trainee will be expected and able to attend (not just a list of all the unit's activities).

d) A logbook from the previous trainee(s)' incorporating a minimum of 12 months operative experience.

5.2.3. The above documents must be submitted to the Chairman of the ANZTBCRS no later than 31 May of the year prior to planned training to allow adequate time for the ANZTBCRS to consider accreditation prior to the following year's job placements being made in late July.

5.2.4. Accreditation of the proposed overseas post will be at the discretion of the ANZTBCRS.

5.2.5. The ANZTBCRS still requires the Trainee to complete all the same requirements as if they were placed in an Australian or New Zealand accredited training position (including a complete logbook, Procedure Based Assessments (PBAs), mid-term and end of year assessments, research, submitting a paper for the Trainees' Weekend, and sitting the exam if in their second year of training).

5.2.6. Prospective accreditation does not guarantee the overseas year will be accepted as part of the two clinical years on the ANZTBCRS Program, particularly, but not only, if there have been any significant changes to the job completed compared to the information provided for prospective accreditation. If the overseas year is not accepted, the Trainee will be required to complete an additional 12 months (or equivalent) of training in an accredited Australian or New Zealand training unit.

6. PROBATIONARY PROCESS

6.1. INDICATIONS FOR PROBATION

If an ANZTBCRS trainee is considered to be underperforming by their Unit supervisors, a probationary plan will be put in place. The following circumstances will lead to a mandatory probation period:

- An unsatisfactory overall assessment in the mid-year assessment, due at the end of June of the training year;
- An unsatisfactory score (1 or 2) in any of the assessment parameters on the mid-year Evaluation Form;
- A request by the Training Unit to the Training Board for the Trainee to be put into a probationary period prior to the mid-year assessment being due. Probation cannot be requested until the Trainee has been on the Unit for at least 3 months.

In addition to the above mandatory probation:

- A borderline score (3 or 4) in any of the assessment parameters on the mid-year Evaluation Form will lead to a telephone conversation between the ANZTBCRS and the Program Director to decide if a probationary plan would be appropriate and/or beneficial.

6.2. PROBATION PLAN

6.2.1. Initial meeting

- Probation will commence with a face-to-face meeting between the Trainee, the Program Director and a member of ANZTBCRS.
- The ANZTBCRS member will be one that that works nearby who is not a member of this Training Unit.
- If there is no suitable local ANZTBCRS member available, a Board member will fly in to manage the commencement of the probation process face to face.
- Prior to this meeting, the Program Director, in conjunction with the other surgeons on the Training Unit, will provide, in writing, a list of the Trainee's deficiencies that need to be addressed during the first probation meeting.
- This list is to be forwarded to the ANZTBCRS member that is managing the probation process prior to the meeting.
- At this meeting, the deficiencies will be discussed in an honest but non-confrontational way with the trainee who will be given an opportunity to respond to each of the Unit's concerns.
- At the completion of this meeting, the ANZTBCRS member will fill out the Probation Form outlining the expectations of the trainee during the probation period. This form will need to be agreed to and signed by all three parties.
- The probation period will be for 16 weeks from the date of the first meeting.

6.2.2. Interim meeting

- There will be an interim meeting 8 weeks after the initial meeting.

- Prior to this interim meeting, all members of the Training Unit will be given the opportunity to comment, by email, to the Program Director, regarding their opinion of the Trainee's progress thus far.
- This information will be shared with the Training Board member involved and the ANZTBCRS Chair.
- The ANZTBCRS will decide whether the Training Board member needs to be present for the interim meeting on the basis of this information.
- The interim meeting will be a formative one only (there will be no assessment) and the Probation period will continue no matter the outcome of this meeting.
- The interim meeting is an opportunity for both the Program Director and the Trainee to comment on how they think things are going and whether any other issues have arisen.
- The outcome will either be a continuation of the Probation under the terms agreed at the first meeting, or a modification of the Probation terms (which can be agreed upon by email) to cover any issues that have arisen in the email correspondence or at the interim meeting.

6.2.3. Final and summative probation meeting

- There will be a final Probation Meeting 16 weeks after the initial meeting.
- The ANZTBCRS member that has managed the probation process for this trainee will be present at the final meeting.
- Prior to this meeting the Training Unit will have completed a formal assessment of the Trainee's performance during probation, by consensus and preferably in a face-to-face meeting involving all of the consultants on the Unit. The form for this process is attached.
- The ANZTBCRS will be informed of the result of the probation prior to the final meeting.
- The results of the probation will be discussed with the trainee at the final meeting.

6.2.4. Outcome of probation

- If the trainee has failed the probation, this will be reflected in an overall Unsatisfactory result on the Probation Evaluation Form. Should this be the case, probation will continue under the same terms for the remainder of the training year.
- If the trainee passes the probation, then, with the agreement of all three parties, the probation can be lifted for the reminder of the training year.
- The probation period should be considered as separate to the overall assessment of the Trainee at the end of the Training year. It is designed to help the Trainee to recognise and work to correct their deficiencies and (hopefully) to turn an unsatisfactory mid-year evaluation (or early concerns raised by the Unit) into a satisfactory end of year evaluation. However, whilst the results of probation may inform the Unit's final evaluation, it is important that all parties are aware that the end of year assessment is a separate and formal process. The Unit should be assessing the whole year when the final assessment is made.
    - A failed probation does not exclude a pass at the end of year assessment.
    - A passed probation does not guarantee a pass at the end of year.

7. ANZTBCRS POLICY PAPER ON PART-TIME TRAINING AND JOB-SHARING DURING TRAINING

7.1. INTRODUCTION

The ANZTBCRS recognises that trainees have different personal requirements for their training. For many this will align with the full-time training offered under the standard ANZTBCRS pathway, however for some trainees this may present significant difficulties. Situations that may make full-time training difficult for a trainee include: pregnancy, significant illness, significant family tragedy. The ANZTBCRS understands that under certain circumstances trainees may benefit from a period of part-time training, possibly including a job-share arrangement. The ANZTBCRS is supportive of established trainees (those already accepted on to the training scheme) applying for part-time or job-shared training. Each application will be assessed on a case-by-case basis, and the ANZTBCRS is not compelled to provide part-time training for every application.

7.2. ELIGIBLE TRAINEES

Trainees already accepted on to the ANZTBCRS training program and having already started either a clinical or accredited research year. This does not include trainees who have been accepted at interview, but who have not started their training the following year.

7.3. SITUATIONS THAT MAY BE CONSIDERED FOR PART-TIME TRAINING

Part-time training (including job-sharing) might be considered when a trainee is established on the training program, and when the trainee's personal situation changes making it difficult to comply with all the requirements of full-time training. It must be demonstrated that the situation clearly impacts the trainee's ability to complete full time training, and that there is a definable endpoint to that situation.

It is not possible to describe all possible situations when a trainee may consider part-time training, nor all possible situations when the ANZTBCRS would or would not accept part-time training.

7.4. PROCESS

When a trainee feels that they cannot complete full time training because of a change in circumstances, they should discuss this with the Program Director of their hospital or Research Supervisor, and notify the ANZTBCRS of this situation. The trainee should clearly define what the situation is and how this affects their ability to train full-time. They should also define the time period they believe this will be for. The ANZTBCRS will consider all applications for part-time and job-sharing arrangements on a case by case basis. The ANZTBCRS will consider part-time or job-sharing arrangements for up to 12 months of equivalent full-time training. For example, a trainee may request job-sharing with a 50/50 split for 12 months. This means that the trainee will have completed 6 months of training during that period, and still requires a further 6 months to complete training. This final 6 months may be either as a part-time (over 12 months), job-sharing (over 12 months) or full-time employment (over 6 months).

Having established that the trainee would benefit from part-time or job-shared training, it is then necessary to establish if there is an appropriate hospital unit available, and in the case of job-sharing, an appropriate "partner" for the job-sharing. The ANZTBCRS will aim to facilitate this process but is not wholly responsible for it. If no appropriate part-time or job-shared training is

available, the trainee has the option of continuing in full-time training or suspending their training until their personal situation allows for full-time training again. The period of suspension would be no more than one year.

SECTION 3: GLOSSARY

ANZTBCRS	Australia and New Zealand Training Board in Colon and Rectal Surgery
CSSANZ	Colorectal Surgical Society of Australia and New Zealand
Section	Colon and Rectal Surgery Section, Royal Australasian College of Surgeons
ASC	Annual Scientific Congress, Royal Australasian College of Surgeons
BCCA	Bi-National Colorectal Cancer Audit
College	Royal Australasian College of Surgeons
CME	Spring Colorectal Meeting
CPD	Continuing Professional Development
FRACS	Fellow of the Royal Australasian College of Surgeons
Journal Club	CSSANZ Journal Club
MALT	Morbidity Audit and Logbook Tool (RACS)
PFET	Post Fellowship Education and Training (RACS)
RACS	Royal Australasian College of Surgeons
Trainees	Trainees on the Post Fellowship ANZTBCRS Program
Training Program	ANZTBCRS Post Fellowship Colorectal Training Program

DEFINITION: ACADEMIC MISCONDUCT

(This definition has been adapted from Royal Australasian College of Surgeons' Policy "Identification and Management of Academic Misconduct" Feb 2008)

Academic Misconduct is defined as:

- an action by a Trainee or other candidate for assessment which is in breach of any lawful direction or directions issued by the ANZTBCRS or College, or conduct on the part of a Trainee or other candidate for assessment that impairs or may impair the reasonable freedom of any other person to pursue his or her studies or assessment activities within the ANZTBCRS or College process.
- conduct on the part of a Trainee or other candidate for assessment that hinders the pursuit of academic excellence by circumvention of established ANZTBCRS or College procedures in relation to assessment.
- cheating by any means, attempting to cheat by any means, or doing anything which may assist another person to cheat in relation to any assessment within the ANZTBCRS or College. Cheating can be defined as seeking to obtain or obtaining an unfair advantage in an assessment.
- plagiarising the work of another person by adapting or incorporating that work in a piece of assessment without appropriate acknowledgement.
- unauthorised collaboration with another Trainee or other candidate for assessment during an examination by any means.
- bringing unauthorised materials or prohibited devices into an examination room or an area where clinical or viva examinations are undertaken.
- making a false representation about matters affecting the individual assessment, including but not limited to impersonation or submitting false documents.
- disrupting or obstructing an official of the ANZTBCRS or College undertaking assessment procedures or supervising assessment procedures.
- inciting academic misconduct in others.

Academic misconduct applies to any training program activity, Trainee examination or assessment process and may involve transgression with respect to any printed material, examination material, viva examination material or clinical material.

A Trainee or other candidate for assessment who attempts to commit academic misconduct is guilty of academic misconduct. A Trainee or other candidate for assessment or other person who assists or attempts to assist another to commit academic misconduct is guilty of academic misconduct.

SECTION 4: CURRICULUM LIST

The following subjects form the content of the curriculum. The trainees will be expected to learn these subjects and be prepared to answer questions relating to them in the final exam.

a) Surgical Anatomy - Anus/Rectum/Colon

b) Physiology - Anus/Rectum/Colon

c) Clinical Diagnosis of diseases of the Anus/Rectum/Colon

d) Investigations

Sigmoidoscopy, Colonoscopy, Virtual Colonoscopy, CT and MRI, PET, Barium Enema, Intrarectal and Endoanal Ultrasound, Manometry, Electromyography, Pudendal nerve terminal motor latency

e) Anorectal Surgery

Principles and general conduct of minor rectal surgery
Lasers and Infra-red coagulation in anorectal Surgery
Haemorrhoids
Anal Fissure
Anorectal Abscess / Anal fistula
Perianal Hidradenitis Suppurativa
Anal Stenosis
Anovaginal Fistula
Pilonidal Disease
Sexually Transmitted Diseases
Anal Manifestations of AIDS
Perianal Condylomata Acuminata
Fourniers Gangrene
Anorectal Inflammatory Conditions
Pruritis Ani
Faecal Impaction
Anorectal Trauma and Foreign bodies
Congenital deformity of the anorectal region

f) Pelvic Floor Disorders

Obstructed defecation (Outlet Obstruction Constipation)
Levator Syndrome / Proctalgia Fugax / Coccygodynia
Rectocele/Pelvic Floor Herniation/Descending Perineum Syndrome
Faecal Incontinence
Rectal Prolapse, complete, internal or "hidden"
Solitary Rectal Ulcer Syndrome

g) Functional disorders of Colon & Rectum

Megacolon and other abnormalities in children
Hirschsprungs Disease
Megacolon
Constipation
Diarrhoea
Irritable bowel syndrome
Ogilvies Syndrome (i.e. Colonic Pseudo obstruction)

h) Neoplasia

Benign Polyps in the Colon and Rectum
Carcinoma of the Anal canal and Anus
Rarer Tumours of the Anus

Colorectal Carcinoma

Incidence and Pathology of carcinoma of colon and rectum
Genetics - HNPCC, FAP and genetic causes of CRC
Clinical Features and Diagnosis of carcinoma of colon and rectum
Treatment of carcinoma of the colon
Treatment of carcinoma of the rectum
Immunology and Immunotherapy of Colorectal Tumours
Hepatic and Pulmonary Metastases
Radiotherapy
Chemotherapy

Pseudomyxoma Peritonei
Rarer tumours of the colon and rectum (including Carcinoid)

i) Inflammatory Bowel Disease

Ulcerative Colitis
Crohns Disease
Other forms of colitis:
Collagenous/Eosinophilic/Neutropenic/Bacterial/Fungal/Parasitic/Viral/
Pseudomembranous/Radiation Proctitis and Enteritis

j) Diverticular Disease

k) Vascular Disorders

Vascular Ectasia
Acute and Chronic Mesenteric Ischaemia
Mesenteric Venous Thrombosis
Ischaemic Colitis
Colonic Haemorrhage

l) Stomas and their care

Ileostomy
Colostomy

m) Miscellaneous

Nonspecific ulceration of the colon
Stricture of the colon and rectum
Injuries of the colon and rectum
Use of the colon as a replacement or bypass for other organs
Rectovaginal Fistula
Volvulus
Pneumatosis Cystoides Intestinalis
Diseases of Appendices Epiploicae
Melanosis Coli
Urological and Gynaecological conditions

n) Other Considerations (Not Specific to Colorectal)

Antibiotics, Respiratory and Cardiac Management of Surgical Patients,
Shock, Fluids and Electrolytes, Renal Physiology,
Blood Transfusion, Blood Component Therapy, Coagulopathies