

**ROYAL AUSTRALASIAN COLLEGE of
SURGEONS**

**ANNUAL REPORT to the
AUSTRALIAN MEDICAL COUNCIL
2008**

COLLEGE DETAILS

NAME: ROYAL AUSTRALASIAN COLLEGE of SURGEONS

**ADDRESS: SPRING STREET
MELBOURNE, VIC 3000**

OFFICER TO CONTACT CONCERNING THE REPORT:

Dr David Hillis, Chief Executive Officer

Telephone: (03) 9249 1205

e-mail: david.hillis@surgeons.org

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EXECUTIVE SUMMARY

Since the AMC accreditation visit in July 2007 the College has successfully moved forward with many elements of the new Surgical Education and Training (SET) program.

- ♦ Some elements such as the commencement of training in SET1 and the transition from Specialist Surgical Training (SST) to SET2+ have occurred very much as planned, as have the necessary changes to the administration, board structures and policies
- ♦ Some elements have been introduced smoothly thanks to the additional efforts that have been put in by small numbers of representatives of some of the specialties plus others. The transition from the Basic Science Examination (BSE), which was formerly part of Basic Surgical Training (BST), to the generic and specialty specific Surgical Science Examination (SSE) falls into this category.
- ♦ Other elements of SET including enhanced communication with stakeholders including supervisors and trainees, and greater congruence between the specialty selection processes are areas that the College will continue to monitor and work on.

During the transition processes we have identified challenges including the:

- ♦ Introduction of new formative assessment approaches, such as DOPS and Mini-CEX, for trainees in the early stages of training. These processes will take more than one year to fully implement because they are based on a significant change in the culture for both trainees and supervisors,
- ♦ Establishment of appropriate processes to define the pass/fail standard of the specialty specific SSE due to the very small numbers in the cohorts sitting that examination

As a consequence of the move from BST and SST to SET each of the specialties will need to review their curriculum to ensure that their modules include all of the competency requirements for the full spectrum of training. In some specialties this process has already commenced, for example, General Surgery has a curriculum development day planned for September.

New initiatives undertaken since July 2007 include:

Taking a leading role in the 2008 International Conference on Surgical Education at which selection was a key issue

Establishing a Faculty of Surgical Educators Steering Group

Establishing a Post Fellowship Education and Training Steering Committee

The structure of this report

This report has two distinct components. The first part is the standard annual report containing responses to the generic questions which the AMC ask every College to report on each year. The second part contains the response to the five areas which the AMC nominated, about which there were several recommendations, and which the AMC wanted the College to specifically report on. Those five areas are:

- (i) Mechanisms agreed with jurisdictions to facilitate resolution of issues of concern, including workforce numbers
- (ii) The development and implementation of an enhanced strategy for communication with stakeholders about SET
- (iii) Evaluation of the selection process
- (iv) Introduction of new in-training assessment processes, including the training of assessors
- (v) Plans to ensure greater coherence between the surgical specialties in key training processes

1 PROCESS OF SPECIALIST EDUCATION AND TRAINING

1.1 Changes to the processes of Specialists Education and Training

- **Goals of education and training:**
No change from the plans which were outlined to the AMC in 2007.

- **Structure and duration of training:**
Plans have progressed as outlined to the AMC in 2007; there was no intake into the Basic Surgical Training (BST) program; in 2008 trainees commenced training in both SET1 and SET2 in each of the nine surgical specialties.

- **Content of education and training program:**
The educational and training program for the remaining BST's is unchanged. The introduction of SET with the addition of the SET 1 year to each of the specialists training programs has been implemented in 2008.

- **Formal education courses:**
No change from the plans which were outlined to the AMC in 2007.

- **Range or organisation of education and training programs in sub-specialties:**
The provision, appropriate supervision and formal academic recognition of post-Fellowship education and training has become a major focus for the College and its various specialty Associations and Societies. The majority of surgeons on completing their specialist training (e.g. obtaining FRACS) proceed to further training in a subspecialty area. This is referred to internationally as Post-fellowship Training (Australia & UK) or Progressive Specialisation (North America) and currently takes place in a haphazard fashion. The College has established a Post Fellowship Education and Training Steering Committee to begin to address the issues of accreditation and recognition of post fellowship training. The Steering Committee comprises representation from relevant specialist societies.

2 TRAINEE ASSESSMENT AND EXAMINATION

2.1 Changes to assessment to reflect changes in educational objectives, including policy and procedures

Changes in the conduct of the Basic Sciences and Clinical Examinations which were described in the 2007 report to the AMC have now been introduced; new policies in relation to the new assessment have been developed and are now on the College website. The policies are consistent and applicable across all nine specialties. For trainees transferring between specialties, recognition of prior learning will apply to the Clinical and Generic Surgical Science Examinations.

The last of the BST Basic Sciences Examinations was conducted in February 2008 and the first SET Surgical Science Examination (SSE) will be conducted in October 2008. Any remaining BST Trainees who have not passed the BST Basic Sciences Examination will have the opportunity to sit the Generic Surgical Sciences Examination. BST Trainees who have successfully completed the BST Basic Sciences Examination (last held in February 2008) will be given RPL for the generic and speciality specific components of the SET Examinations once they are successful in being selected into the SET program. BSTs who have successfully completed the Clinical Examination will likewise be given RPL.

The new SET Surgical Sciences Examination relates to the College competency of medical expertise and assesses candidates' knowledge, understanding and application of anatomy pathology and physiology as they apply to generic and speciality specific situations in health and disease. The Generic SET SSE consists of two papers of 120 questions, each containing questions on anatomy, physiology and pathology.

Specialty Specific papers for Cardiothoracic Surgery, General Surgery/Urology, Neurosurgery, Otolaryngology Head and Neck Surgery, and Vascular Surgery, each contain 120 questions (with varying number of questions in the three subject disciplines). General Surgery and Urology will share the same (specialty specific) paper.

Orthopaedic Surgery, Paediatric Surgery and Plastic and Reconstructive Surgery will continue to conduct their existing specialty-specific examinations (early examination) in the same format as they have done previously i.e. the Orthopaedic Principles and Basic Science, the Paediatric Anatomy and Pathology Examination and the Plastic and Reconstructive Surgical Science and Principles Examinations.

The composition and conduct of the Clinical Examination remains unchanged and will be the same for all nine specialties.

It is the expectation that the Generic SSE and Clinical Examinations will be successfully completed by the end of SET1. However the policy allows for a two year time frame in which to successfully complete these examinations. The Specialty Specific SSE must also be completed in the same two year time- frame.

Following the success of implementation of the SAT SET Course a significant number of Fellows (over 500) are now better equipped to undertake in-training assessment and provide feedback to Trainees. The workplace assessment based tools are being rolled out across the nine specialties at varying speed depending on the number of Fellows who have undertaken SAT SET Course. Each of the nine specialties has decided on the most appropriate mechanism for this implementation and the formal feedback to the Board of SET confirms that this is a work in progress.

2.2 Identification and management of under-performing trainees

Training policies, including SET Assessment of Clinical Training (February 2008) and SET Dismissal from Surgical Training (June 2007), have been reviewed and revised to better define the process of managing the underperforming trainee; improvement in the Boards' processes have been noted. The College has been advised by all of the Specialty Boards that they are undertaking the management of the underperforming trainee according to the above policies. It is acknowledged that with the more junior entry level into specialist surgical training, the Speciality Boards are managing a more junior cohort than previously, expertise which has previously been the domain of the Board of BST.

Consequently, support and education for supervisors eg access to SAT SET courses, is identified as a critical component of managing under performance. Also refer 4.3 – Faculty of Surgical Educators Steering Group.

The College continues to discuss with the Jurisdictions approaches that will provide adequate time for supervisory and assessment activities and has been responsive and flexible in working with the Boards to provide access to SAT SET for supervisors.

3 ACCREDITATION OF INSTITUTIONS, TRAINING PROGRAMS AND POSITIONS

3.1 Changes to the processes of accreditation

- Changes to accreditation policy or principles:
No change from the processes which were outlined to the AMC in 2007

- Changes to the criteria for accreditation:
No change from the processes which were outlined to the AMC in 2007

- Mechanisms for monitoring the adequacy, supervision and organisation of clinical placements:
Mechanisms continue to ensure that each trainee obtains appropriate experience under supervision at each site. Ongoing evaluation of the quality of the post is carried out at the end of each rotation though reviewing trainees' logbooks and evaluations of their training experience (also see Section 5 Trainees).

3.2 Accreditation of SET 1 training positions:

Appropriate SET 1 positions were identified by the Speciality Boards using a paper based assessment process. It should be noted that there were more positions accredited than selected trainees.

This process was not repeated for 2008; the posts identified will carry over to 2009 and fall into in the quinquennial accreditation process for SET 2-5 posts.

3.3 Access to outpatient and ambulatory experience:

This was discussed during the 2007 accreditation when it was pointed out that the absence of consultative clinics in NSW remained a problem. The College has raised this with the appropriate authorities in the past but it is powerless to change what is established practice. The criteria for the accreditation of hospitals does highlight however, the need for a hospital to have in place appropriate outpatient and clinical experiences for surgical trainees before that site will be accredited for training.

3.4 The impact of SET on availability of flexible training opportunities

With the introduction of SET, there has been no discernible impact on the availability of flexible training opportunities. Although the College supports flexibility in training, the constraints of employer and workforce requirements often make such flexible arrangements difficult for the trainee to achieve.

In South Australia, 2 places have been negotiated between an employer and the Board in General Surgery but these are currently not filled. RACSTA has undertaken to develop mechanisms to promote and review these positions. The 'structure' for each training post is to be reviewed as well so as to provide a model for other regions interested in providing flexible posts.

4 SUPERVISORS, ASSESSORS, TRAINERS AND MENTORS

4.1 Changes to the appointment process for supervisors

Clearer details have been provided in the document for accreditation of hospitals for surgical training on how supervisors are appointed and also what their roles are.

4.2 Communication with Supervisors

There are differences between the surgical specialties in the ways they communicate with their Supervisors. In some specialties the majority of their Supervisors constitute their regional training committees which are then represented on the Specialty Board; many of the specialties have annual scientific meetings at which there are Supervisors meetings; and several have regular contact with Supervisors through e-mail and/or newsletters (see Appendix B).

4.3 Faculty of Surgical Educators Steering Group

In recognition of the importance of having a skilled and educated faculty to deliver the training programs, the College has tasked the steering group with developing a framework for development of faculty across all levels. This will include further support and development of supervisors and assessors. The Steering Group's recommendations will be presented to Council in June 2009.

5 ISSUES RELATING TO TRAINEES

5.1 Selection (see the Supplementary Report)

5.2 Royal Australasian College of Surgeons Trainees' Association (RACSTA)

RACSTA continues to grow in its influence and is represented on all College boards and committees deemed relevant to surgical trainees, including College Council. Through its Chair and other members, RACSTA has made a very important and useful contributions to College discussion and decision-making on issues affecting trainees.

RACSTA is developing in its role and importance to trainees. An Australian and New Zealand-wide network has been established, providing support at both a specialty and regional level. There exists a RACSTA website which provides trainees with access to RACSTA committee members and information relevant to their training and education. The RACSTA committee meets frequently and divides its attention into three distinct portfolios to ensure forward progression of issues. These are Education, Advocacy and Support, and Workplace Relations. Current issues include flexible training, feedback on training posts, safe working hours, and mentoring support for trainees. Members of the RACSTA committee are active elsewhere within the College in response to requests for trainee representation.

5.3 Communication with Trainees

Besides RACSTA, the specialties each communicate with, and receive feedback from the trainees in a variety of ways. Three of the larger specialties have their own trainee associations; all specialties have representatives on their specialty boards; several have regular scientific meetings for trainees (or special meetings during their ASM); one specialty interviews every trainee annually; most have a designated employee for trainee contact; and all specialties maintain regular email and mail communication with their trainees. See Appendix C).

RACSTA wishes to explore the matter further to ensure that each individual training post is providing quality training opportunities.

6 OUTPUTS AND OUTCOMES OF TRAINING

6.1 Numbers of trainees entering the training program

In 2007, 1,537 individuals applied for selection across the nine specialties (see Activities report pages 31-37) this number more than doubled that of 422 in 2006. The increase in 2007 was accounted for by the implementation of SET and the opportunity to commence training in SET1 and SET2. Four hundred and seventy-six appointments were made to the training program, 56% of whom were Basic Surgical Trainees (BST). The remainder were made up of trainees already in specialty-specific training, international medical graduates and 90 new persons. See the 2007 Activities Report — Appendix A Page **37**

The disparity between the number of training posts and the number of suitable applicants for positions continues. The College has requested that over 50 new training positions per year be established but very few new positions have been forthcoming at this time. The College is working cooperatively with the Department of Health and Ageing (DoHA) in Australia to identify new posts in both public hospitals and in the private sector. (see Supplementary Report)

6.2 The number of trainees who completed training

A total of 262 new Fellows were admitted in 2007, 42 of whom were women. Refer to the 2008 Activities Report Appendix A, pages 64-67.

6.3 Formative Assessment

Each of the specialties conduct formative assessments throughout training through their In-Training Assessment forms (ITA) and their Log Books. In-training assessment is carried out on a three monthly cycle and reports are submitted to the Board at the end of each rotation (3 months in SET1, 6 months in SET2+). The Log Books are also submitted at the end of each rotation.

Additional formative assessment – Mini-CEX and DOPS - have been introduced from the commencement of SET. Information about the impact of these processes is in the 'Supplementary Report'.

6.4 Summative Assessment

The BST examinations comprise a Clinical Examination and Basic Sciences Examination (BSE). The results of these two examinations are provided in the Activities Report on pages 10-11. In the year to 31 December 2007 there was an increase of 33% in the number of BSTs who sat the BSE examination: 98% of those who sat the examination were successful; 249 BSTs sat the Basic Sciences Examination in 2007 and the overall annual pass rate achieved was 91%.

258 candidates sat the Fellowship Examination (exit examination) in 2007 which was an increase of 33 from 2006. 210 candidates passed the examination giving an annual pass rate of 81%. Comprehensive details on the Fellowship Examination are provided on pages 48-50 of the Activities Report (Appendix A).

6.5 Measures of validity and reliability of assessment processes.

The College has implemented a cycle of review regarding the summative assessments.

- The Basic Science Examination in the BST has had a standardised assessment process for four years.

Initially the University of Melbourne's Assessment Research Centre (MU-ARC) was engaged to measure the reliability and validity of the BSE on an ongoing basis. This has resulted in robust data spanning over four years. In 2004, the College adopted a formal standard setting procedure, acting on expert advice from the MU-ARC to ensure that the BSE pass mark would reflect a

competent performance in the examination, and that it would be robust to variations in exam difficulty and candidate ability from year to year. This process will continue to be applied to the generic component of the SET SSE.

- In 2007 the College trialled measures to review the standard of the Clinical Examination using a modified Global assessment Scale process. This will be formally introduced in October 2008.

For the SET Clinical Examination the mark required to pass each station will be the mean score of those candidates judged to have completed the station at a 'borderline pass' or 'borderline fail' level, according to their scores on the Global Rating Scale. The minimum passing score for the whole exam will be the sum of the sixteen station pass marks plus one standard error of measurement. In order to pass the exam, candidates must pass at least two stations of each type (Examination, Communication, History and Procedure) as well as achieving the minimum passing score for the whole exam.

In 2008 a 'bookmarking' process is being introduced for the specialty specific Surgical Science Examination (SSE) in Cardiothoracic Surgery; General Surgery & Urology; Neurosurgery; Otolaryngology Head and Neck Surgery; and Vascular Surgery

Because of the smaller number of candidates at each sitting, the specialty specific SSEs pose new challenges to the standard setting process. Based on the recommendations of (MU-ARC) a modified 'Bookmark' standard setting procedure is being introduced for the October 2008 Specialty Specific SSEs with representatives from each of the six specialties being trained in standard setting for their SSE. Rather than a statistical approach to standard setting the 'Bookmark' standard is established by a panel of experts initially defining the knowledge and skills of a 'minimally competent candidate' (MCC). This MCC is then considered, through a number of iterations, in relation to the level of difficulty of the exam questions until the point at which an MCC is no longer able to answer an item correctly with at least a 50% probability is identified and agreed upon.

- In 2007 and 2008 the Fellowship Examination has been evaluated for its reliability and validity.

This evaluation is in its initial stages. The first stage involves a detailed analysis of the pass/fail rate between specialties and for each of the seven components of the examination within specialties. One of the key issues guiding this evaluation is to ensure that each of the specialties is interpreting the marking system in the same way, and at each examination. This is a very detailed analysis using data going back to 2001.

7 EVALUATION OF THE PROGRAM

Evaluation of the SET program continues through a number of different evaluation processes. General Surgery and Orthopaedic Surgery have trainee evaluation forms which are completed by each trainee at the end of each rotation. Vascular Surgery, Neurosurgery, Otolaryngology Head and Neck Surgery and Paediatric Surgery have annual trainee meetings where the trainees are either interviewed individually or have group meetings. The information collected through each of these mechanisms is discussed by the appropriate Specialty Board in order to continually improve the program.

7.1 Changes to the evaluation and monitoring of quality of the training program

- New evaluation activities initiated.
Evaluation of the selection processes of all specialties – refer Supplementary Report

- Evaluation activities completed
An evaluation of the Fellowship Examination has been undertaken (see 6.5), the outcome of which has been discussed by the Court of Examiners and the Education Board. Each specialty is addressing the issues raised by this evaluation.

- A survey of those who registered but did not proceed to application is being undertaken to determine if process improvements can be made.

- Changes in the resources available to support the program
The training program is adequately funded and resourced

8 ASSESSMENT OF OVERSEAS TRAINED SPECIALISTS

8.1 Changes or planned changes to the process for assessing overseas-trained specialists

The College has a clearly established mechanism for the assessment of overseas trained specialists and no changes have taken place since the last report to the AMC. Extensive discussion has taken place under the offices of COAG and a suggested new process is under discussion with each of the medical colleges. RACS continue to use its established process to establish the level of comparability of an overseas trained specialist compared to an Australian trained specialist. Ongoing issues remain surrounding Area of Need positions and the provision of appropriate supervision of surgeons in these areas. A further controversy relates to the Colleges' role in assessing overseas specialists in training who come to Australia for short term training and the appropriateness or otherwise of hospital positions for which they have applied.. .

86 international medical graduates were selected to the SET program in 2007. 19 international medical graduates completed the Fellowship Examination in 2007.

9 CONTINUING PROFESSIONAL DEVELOPMENT PROGRAMS

9.1 Changes or planned changes to the continuing professional development programs

- Changes to policy or principles relating to continuing professional development:
No change from the processes which were outlined to the AMC in 2007.

- Changes to the categories of activity recognised for continuing professional development:
No change from the processes which were outlined to the AMC in 2007.

- Changes to the College's process for endorsement of educational activities/meetings:
No change from the processes which were outlined to the AMC in 2007.

- Initiatives to evaluate professional development programs:
No change from the processes which were outlined to the AMC in 2007

9.2 Rates of participation by College Fellows

The current triennium cycle will finish in December 2009. CPD participation rates continue to be high. Refer to the 2007 Activities Report, Appendix A pages 68-71.

9.3 Non-Technical Competencies

A major development in this area has been the development of a College Guide on Surgical Competence and Performance. The College has identified the need to develop better processes for assessing the performance of practicing surgeons and this document has been developed to offer support and remediation to surgeons where this is appropriate. The working party developed the Surgical Competence and Performance Guide presents a framework for assessing performance under the nine RACS competencies. Example of good and poor behavioural markers has been developed for each of these competencies. This innovative document will enable surgeons to undertake self assessment as well as being available for remediation to surgeons where necessary.

Refer Appendix D Surgical Competence and Performance Project booklet.

Appendices

- Appendix A [RACS Activities Report January – December, 2007](#)
- Appendix B Table showing interaction between each Specialty Board and their Supervisors
- Appendix C Table showing interaction between each Specialty Board and their Trainees
- Appendix D Surgical Competence and Performance Booklet (sent as a separate PDF file)
- Appendix E Report from the International Conference on Surgical Education

Appendix B

Specialty Boards - Communication with Supervisors

	Majority of supervisors members of state committees	Majority of supervisors members of Board	Board convenes special meeting(s) with supervisors	Annual scientific meeting	Other
Cardiothoracic					Regular email and mail communication
General	Regional training sub-committees have meetings throughout the year (amounts vary from state to state)	State (or NZ) Head of training is a member of Board			Regular email, phone and mail communication.
Neurosurgery			Yes – see ASM	Meeting with supervisors during the ASM	Bi-monthly SET Program in Neurosurgery newsletters (emailed)
Otolaryngology Head & Neck	Regional training sub-committees have meetings throughout the year (amounts vary from state to state)			Special meeting at ASM for supervisors	
Orthopaedic	All supervisors are members of their state-based Regional Training Committee (RTC). In NSW, supervisors sit on both a geographically-based “Board of Studies” and a Regional Training Committee. RTCs meet quarterly.	No RTC Chairmen sit on the AOA Training Committee. The Training Committee meets three times per year.		The AOA Training Committee meets at the AOA ASM. Meetings and seminars addressing education and supervision are convened on an ad hoc basis.	Regular e-mail communication.
Paediatric			X2 per year		Regular e-mail communication
Plastic & Reconstructive					Regular e-mail communication
Urology	All urology supervisors are members of the Section (State or NZ) training committee	State (or NZ) Head of training is a member of Board of Urology		Meeting of trainees and supervisors at ASM	Regular e-mail communication
Vascular	Not applicable for smaller specialties	State (or NZ) Head of training is a member of Board	Board meets supervisors in each Region, depending on where the Board meeting is being held.	Meeting of all vascular supervisors is held at the ASC.	Regular email communication

Appendix C

Specialty Boards - Communication with Trainees

	Trainee association	Trainees represented on Board	Trainee evaluation of each rotation	Annual scientific meeting	Other
Cardiothoracic					Regular email and mail communication
General	✓ Regional meetings of RACSTA are minuted and sent to the regional offices	Trainee rep attends face to face Board in General Surgery meetings		GSA has ASM which trainees are invited to attend at a reduced rate	New trainee manual will be sent to 2009 trainees. Quarterly E Newsletter planned for 2009.
Neurosurgery	✓	✓	commenced in 2008	Trainee breakfast meeting with Board Chairman	Bi-monthly SET Program in Neurosurgery newsletters (emailed) & discussion forums during twice yearly compulsory trainee seminar
Otolaryngology Head & Neck		Trainee Rep on Board		Annual trainee conference	Designated employee for trainee contact Trainees evaluate each rotation at their 6 monthly interview
Orthopaedic	Trainees can become members of AORA (Australian Orthopaedic Registrars' Association)	There is a registrar representative on each RTC and on the AOA Training Committee.	Trainees are asked to complete a "Trainee Report on Hospital Post" evaluation form at the end of each rotation.	Trainees are invited to participate in the AOA ASM. AORA also convenes an annual conference.	Regular email contact. The AOA Training Officer is the designated contact for Orthopaedic trainees.
Paediatric					Annual individual interviews
Plastic & Reconstructive	✓	✓			Annual Registrars' Conference. Interviews during Accreditation Inspections.
Urology		✓	✓	✓	Has a designated employee for trainee contact Trainee meeting held during registrar trainee week
Vascular	✓	✓	✓		Trainee interviews are held annually. Trainees are invited to attend a trainees' meeting scheduled in each state when Board meeting is held in that state. Regular email communication

Appendix E

The Melbourne 2008 International Consensus Statement on Selection of Doctors for Training as Surgeons

- Selection must aim to identify those doctors with the values, attitudes and aptitude required to become competent surgeons.
- Responsibility for selection must involve members of the surgical profession trained in selection methodology and the agencies (including employers) responsible for the delivery of education and training.
- Potential for successful education and training in a particular specialty program is the basis for selection and not the extent of prior knowledge, experience and skills in that specialty.
- Early selection into a surgical training program must be accompanied by clearly established grounds and methodology to ensure struggling or underperforming trainees do not progress unless competency deficiencies are rectified.
- Selection methodology must be predetermined, transparent, include a broad range of approaches to maximise validity and reliability, involve multiple raters, contain clear criteria for marking and allocate weighting for each tool which permits ranking of applicants.
- Eligibility criteria (long-listing) for application to specialist surgical education and training should include generic and specialty specific components.
- Structured curricula vitae provide important verifiable biographical information on clinical experience, academic and other accomplishments.
- Knowledge is an essential base for clinical reasoning and judgment and the level of a candidate's knowledge at the extremes of performance is a good predictor of their future overall performance.
- Structured referees' reports can provide credible information from surgeons, colleagues, other healthcare professionals and employers based on their firsthand experience of a doctor's performance in the working and learning environment.
- Structured interviews should use questions which target specific competencies identified through job analysis, and yield important information not available from other selection tools.

ROYAL AUSTRALASIAN COLLEGE of SURGEONS

SUPPLEMENTARY REPORT to the
AUSTRALIAN MEDICAL COUNCIL
2008

COLLEGE DETAILS

NAME: ROYAL AUSTRALASIAN COLLEGE of SURGEONS

ADDRESS: SPRING STREET
MELBOURNE, VIC 3000

OFFICER TO CONTACT CONCERNING THE REPORT:

Dr David Hillis, Chief Executive Officer

Telephone: (03) 9249 1205

e-mail: david.hillis@surgeons.org

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EXECUTIVE SUMMARY

This report is supplementary to the Annual Report to the Australian Medical Council 2008 addressing the five reporting areas that were highlighted by the Specialist Education Accreditation Committee:

That the AMC grant accreditation of the Surgical Education and Training program and the continuing professional development programs of the Royal Australasian College of Surgeons until December 2011, subject to ... a satisfactory report to the Specialist Education Accreditation Committee responding to the recommendations made in this report on:

- (i) Mechanisms agreed with jurisdictions to facilitate resolution of issues of concern, including workforce numbers
- (ii) The development and implementation of an enhanced strategy for communication with stakeholders about SET
- (iii) Evaluation of the selection process
- (iv) Introduction of new in-training assessment processes, including the training of assessors
- (v) Plans to ensure greater coherence between the surgical specialties in key training processes.

1 Mechanisms agreed with jurisdictions to facilitate resolution of issues of concern, including workforce number

1.1 Communication with Jurisdictions

Following the review of the College's training programs by the Australian Medical Council, the College engaged Mr John Ramsay of Ramsay Consulting to actively engage with the various Health Departments about improving the methods of communication. A draft paper was circulated in late 2007 and, after further input, was revised for consideration by the February meeting of the College Council. This latter paper attempted to streamline the interactions between the College, its regional and associated specialty groups with the various Government agencies.

The Health Workforce Principal Committee will shortly provide feedback as to which College committee structures they believe jurisdictional representation is of value and the frequency at which this should occur. In the interim the various Regional Committees have raised the importance of involving all the surgical specialties in their deliberations and particularly as they interface with their Departments of Health and Government structures.

The Chief Executive of the College and the Chair of the Health Workforce Principal Committee have met and committed to resolve further outstanding issues in the near future.

1.2 Expansion of training settings

The College continues to work with the Commonwealth Department of Health and Ageing to identify new positions in expanded training settings. The College had acquired Federal Government funding for a Project Officer to work with the Specialty Boards to identify training positions. There was also funding available to inspect the positions. Funding for the positions themselves were dependent upon them being accredited by the College, and placed with a College trainee.

A meeting between the College and the Department of Ageing was held on August 8, 2008. At that meeting agreement was reached that 16 new posts will be funded by the government. An additional 6.65 FTE post in expanded settings have been identified for 2009, pending accreditation. More details about this will be available at the time the AMC visits the College.

2 The development and implementation of an enhanced strategy for communication with stakeholders about SET

2.1 Trainees

The College continues to provide opportunities for interaction with trainees and medical graduates to discuss areas of improved communication with the College. This includes attendance at the College's Annual Scientific Congress, Regional Annual Scientific Meetings, and distributed copies of the ANZ Journal of Surgery, Surgical News, Council Highlights and other material. The College has re-fashioned its web presence for medical students after detailed review by the Dean of Education and a number of medical students.

The College buildings continue to be accessed for educational events and as an example was a major tour focus at the Annual Conference of the Australian Medical Students Association meeting in Melbourne in July 2008. This was highly rated.

2.2 College of Surgical Specialties

Three (once at the ASC and at two Council meetings) times a year the College hosts a 'Surgical Leaders Forum', bringing together the Presidents of Specialty Societies, the Chairs of the Specialty Training Boards and the Executive of the College council. The purpose of these meetings is to discuss issues of mutual interest such as the MOU and Service agreements or changes in government requirements of medical groups. In addition, issues that require collaboration such as selection, IMGs and hospital accreditation, as well as new initiatives of the College such as SET and the establishment of a Faculty of Surgical Educators are also discussed.

General Surgery Australia is now assuming more responsibility for the management of the training program. One of their first actions in this larger role will be the appointment of a full time Education Manager. With this transition the College can more fully move into the role of being the "College of Surgical Specialties".

The Director of Education and Training Administration will be arranging regular meetings of all the key educational staff of the Specialty societies to improve communication and coordination between the various specialties. It is anticipated that these will occur at least twice a year with the focus initially being on the administrative / selection / assessment responsibilities of the program but then expand on the curricula development that is in place.

2.3 Consumer Involvement

On Council and the Education Board Expert Community Advisors bring expertise to the discussions held. The College is engaged in discussion with these advisors to determine the best way to bring appropriate community opinion to the College's decision-making bodies. The College is actively contributing to the initiatives of the Australian Commission on Safety and Quality in Health care which is undertaking broad consultation on Consumer Engagement Strategies.

2.4 Ongoing Feedback

The College is reviewing a number of methods of obtaining feedback from trainees, supervisors and training institutions. As an example, a detailed survey of supervisors and other trainers will be undertaken over the next 6 months about the way that support, infrastructure and educational activities can be provided to supervisors. The outcome of this will be broadly distributed to all hospitals requesting feedback and consultation

3 Evaluation of the selection process

Issues raised by the AMC Accreditation team were discussed at the Surgical Education and Training Board (BSET) in October 2007 and at subsequent meetings leading into the 2009 selection round. A major effort is being undertaken to reach greater uniformity between the nine specialties on the process and criteria for selection. It was specifically highlighted that the selection processes and criteria for 2008 must be supported by evidence – based education rationale and based on sound educational principles.

3.1 The College's role in selection

In order to increase the uniformity between the specialties the following actions have taken place:

- College Policy on selection has been revised
- All nine specialties agreed to use three selection tools which are structured referee reports (35-45%), CV (15-25%) and interview (35–45%)
- All of the selection tools will focus on the nine RACS competencies
- Further discussion has taken place on selection at each meeting of BSET during 2008. At the most recent meeting in June, the Chair asked each Board to report on processes and criteria which they were using for selection in 2008 and to comment and how these related to what has been published on the College website.
- Selection and the need for standardisation and uniformity has been discussed as an agenda item at the meeting of the Presidents of the Surgical Societies and Associations, College Councillors and staff
- Meeting held of College staff with the Executive Officers of the nine specialties to gain input to the selection process and to communicate processes and policy
- The development of the on-line CV and Referee reports aligned with appropriate competencies which were used by six of the specialties
- Evaluation of the processes and criteria used for selection for the nine specialties during 2007 and again in 2008. The results of that evaluation are indicated in the table below.

3.2 International Conference on Surgical Education

The College conducted an International Conference on Surgical Education and Training with selection being the major focus. A consensus statement on the principles of selection was agreed by the delegates from the 13 countries involved. Refer Appendix E.

3.3 Table 1: Evaluation findings on selection processes

Findings	College response
<p>Agreed weighting of tools</p> <p>In 2008 all specialities adhered to the agreed overall percentage allocation of scores for each selection tool</p>	<p>Monitoring will be on-going</p>
<p>Publishing selection information on the website</p> <p>All specialities published their selection criteria and information on the web. With the exception of one speciality, the specialities adhered to the published criteria and process for selection.</p> <p>One specialty was found to have changed their selection processes after they had been agreed on by Council and published on the website in November 2007</p>	<p>This process will be repeated for 2009 selection.</p> <p>The College spoke with the specialty concerned and identified where the problem had arisen; assurance given there would be no repetition.</p>
<p>CVs</p> <p>Whilst 6 specialties have used the College on-line CV the alignment and weighing of competencies within the CV varies between the specialties</p>	<p>More work is required to achieve a greater degree of uniformity.</p> <p>A detailed analysis of the content, weighing within the CVs in relation to competencies, and use of the CVs will be carried out</p>
<p>Referee Reports</p> <p>The source of referee's reports (RR), the number requested, who makes the final decision on which referee will be used and how they are scored differs between the specialties</p>	<p>Ongoing discussion is taking place with the different specialties in order to improve the quality and use of the Referee Reports</p>
<p>Interviews</p> <p>Two specialties are short listing on the basis on each tool independently.</p>	<p>It was agreed in October 2007 that short listing for interview was to be based on an applicant achieving minimum criteria in each of the other two selection tools. This will be discussed again at the BSET meeting in October</p>

<p>The number of selection interview panels, the number of interviewers in each panel and the interview content varies between the specialties</p>	<p>Research is being carried out to identify the most effective and un-biased way to organise interviews</p>
<p>There are concerns about the impact of the 'halo effect' in some specialties where people involved in short listing for interview and the actual interview already know the scores in the other two tools. In the smaller specialties the interviewers know all or most of the applicants.</p>	<p>This is unavoidable in the smaller specialties but those involved are aware of this point and adjust their interview panel(s) accordingly</p> <p>Ways to address the impact of the 'halo effect' will be discussed at future meetings of BSET.</p>
<p>One specialty incorporated psychometric testing into the process although they used this as an adjunct rather than a decision making tool.</p>	<p>A College decision had already been made that psychometric testing does not have a role in the selection of surgical trainees at this time. This decision was based on international consultation and a full review of the published material on this topic. The college consulted with the specialty to get their assurances that the results would not affect the selection outcomes.</p>
<p>Cut point</p> <p>Because there is no pre-defined mechanism for dealing with applicants whose scores are on or near to the cut-point there are frequently very small differences between applicants who are selected and those who are not.</p>	<p>Specialties will be asked to agree on a predefined methodology to deal with candidates who scores place them at a cut-point</p>

The selection round for 2008 has been completed and the processes and documents from each specialty are currently being reviewed. The findings of this review will be fully discussed at the forthcoming BSET meeting in October at which time the new processes and criteria to be used in 2009 will be discussed. The final details will be published on the College and Specialty websites by November 2008.

It is acknowledged that the move to greater uniformity and standardisation is a work in progress. Selection remains contentious with steady but slow progress in the implementation of evidence based processes and criteria.

4 Introduction of new in-training assessment processes, including the training of assessors

4.1 Training of supervisors and assessors (SAT SET)

At June 30, 2008 approximately 500 supervisors and trainers had participated in the Supervisors and Trainers for SET (SAT SET) Course since it was introduced in May 2007. By the end of 2008 over thirty courses will have been conducted. This includes twelve courses offered in rural and regional centres: Bunbury (WA); Orange, Wagga and Coffs Harbour (NSW); Geelong, Traralgon and Bendigo (Vic); Hobart (Tas); Cairns and Coolumb (Qld); Bay of Islands and Palmerston North (NZ).

Some Boards have engaged with the Professional Development Department to co-ordinate access to SAT SET Courses specifically for their supervisors.

Forty surgeons from across Australia and New Zealand have currently been trained as course facilitators during the two facilitator training workshops

Given the positive response and level of voluntary up-take of the SAT SET course in the first 12 months since its inception there are no plans at the moment for making the program mandatory for all supervisors and trainers.

4.2 Changes on the workload of Supervisors after the introduction of SET

With the introduction of the SET1, there has been an increase in the number of specialty trainees and consequently an increased number of supervisors in the early stages of specialty training. However, there has not been an overall increase of the number of supervisors.

It is too early for us to have collected clear information about supervisors' workloads even though we have some anecdotal, and at times conflicting, feedback from some specialties about workloads. There is no firm evidence at this stage currently to indicate that supervisor workloads have increased significantly.

4.3 Feedback on the impact of DOPs and Mini-CEX

Anecdotal information from some of the Specialty Board meetings which have occurred in the second half of this year indicates that the successful introduction of DOPS and Mini-CEX depends upon SET1 trainees taking the responsibility to ensure that they are assessed, as well as the supervisor involvement in assessment.

Because of the variable pace with which specialties have been able to introduce these assessment processes, and the variable response of trainees, we have no clear trends at this stage of the impact of DOPS and Mini-CEX.

4.4 Changes to summative assessment – exit examination

Until the workplace based assessment processes are fully incorporated across the entire training program, it is not possible at this time to evaluate elements of the exit examination that could be addressed earlier in the program. Therefore a review of the Fellowship examination in this context is not being undertaken at this time.

5 Plans to ensure greater coherence between the surgical specialties in key training processes

5.1 Communication with the Boards

The College continues to develop and review its policies on all aspects of the training program; extensive consultation with the Speciality Boards is undertaken to ensure understanding and compliance. As outlined in (3), consultation with the Boards will be ongoing.

5.2 Progress on the introduction of Competency Based Training

The College's continues to take a slow and careful approach to the implementation of competency-based training (CBT). Due attention to the progress being made internationally in the introduction of CBT and the need to maintain the high standard of the current training program will continue. To date, the following measures towards CBT have been implemented:

- The College has developed its policy on Recognition of Prior Learning and Credit Transfer. The revised Policy is currently being considered by the Specialty Boards before final approval in October.
- The Board in General Surgery have introduced the Fundamentals of Laparoscopic Surgery (FLS) program as a component of training for the SET 2 year. It is anticipated this skills training program and validated assessment will be mandated in 2009.
- Through ASERNIP-S, the College is undertaking a significant research project - Surgical Simulation Skills Project. The expected outcome is to provide validated evidence in support of simulation training in addition to a curriculum for laparoscopic skills training. The project is to be completed by 2010.
- The SAT SET Courses for Supervisors which demonstrate the use of the Mini CEX and DOPS for workplace based assessment has been very successful with 500 Fellows undertaking this course in the first 12 months.
- Work on aligning the competencies to curriculum is continuing. It is proposed to have a workshop on aligning curriculum and assessment with the specialty Fellowship Examination Courts.



A GUIDE BY
THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL COMPETENCE AND PERFORMANCE

RACS
Competence
& RACS
Performance

Further information:

Department of Professional Standards
Royal Australasian College of Surgeons
College of Surgeons Gardens
Spring Street
Melbourne
Victoria 3000
Australia

Phone: +61 3 9249 1274

Fax: +61 3 9276 7432

www.surgeons.org/publications

First edition - June 2008

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Foreword

The College is committed to ensuring the highest standard of safe and comprehensive surgical care. We acknowledge the varied challenges for surgeons today and the commitment of all surgeons to lifelong learning and ongoing self-reflection on their practice and performance.

To aid these processes, and to complement the existing College Continuing Professional Development recertification program, Council has identified the need to develop better processes for assessing the performance of practising surgeons. The intent is to offer support and remediation to surgeons where this is appropriate.

Over the past two years, the Surgical Competence and Performance Working Party, under the governance oversight of the Professional Development and Standards Board, has developed a number of guidelines to support these processes, including: re-entry/re-skilling guidelines; management of audit outliers; complaints process; and clinical standards review. These publications are available on the College web site and are referenced in this booklet.

This *Surgical Competence and Performance Guide* aims to describe a framework for the assessment of performance of practising surgeons. It is intended to be used initially as an aid for self-reflection and may also be a useful tool when the performance of a surgeon is under question.

Funding to assist with the development of this guide was provided by Avant Insurance, MDA National Insurance and the Medical Insurance Group Australia. This followed discussion with the Committee of Presidents of Medical Colleges/Australian Medical Association Risk Management working party and the Medical Indemnity Industry Association of Australia. The College is grateful for this support and has agreed to make this guide available to the CPMC for adaptation by other medical colleges in Australia and New Zealand.

We encourage all Fellows of the College to read this guide and discuss the framework and processes described with your surgical colleagues.



Dr Ian Dickinson FRACS
Chair, Surgical Competence and Performance Working Party
Vice President



Prof Ian Gough FRACS
President



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Introduction

This Surgical Competence and Performance guide presents a framework for assessing performance of practising surgeons in all areas of surgical practice and across all of the defined College competencies.

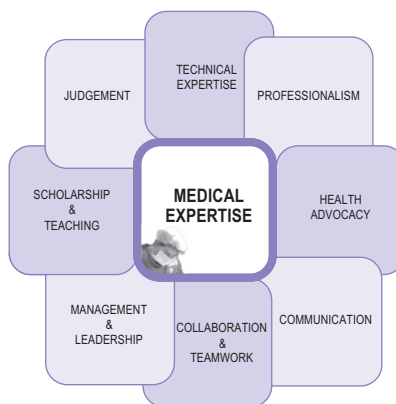
The guide describes a range of specific tools that can be used to assess performance, and provides information to support surgeons who may be underperforming, or at risk of underperforming.

RACS Competencies

In 2003 and in consultation with the fellowship and surgical specialty societies and associations, the College identified nine competencies of a surgeon. These competencies underpin all aspects of fellowship training and the aim of College training and development programs is to certify/recertify specialist surgeons with the following attributes:

- Medical Expertise
- Judgement – Clinical Decision Making
- Technical Expertise
- Professionalism
- Health Advocacy
- Communication
- Collaboration
- Management and Leadership
- Scholarship / Teaching

These competencies provide the framework to assess performance of practising surgeons. Each competency is vitally and equally important to the achievement of the highest standards of surgical performance (Collins et al., 2007).

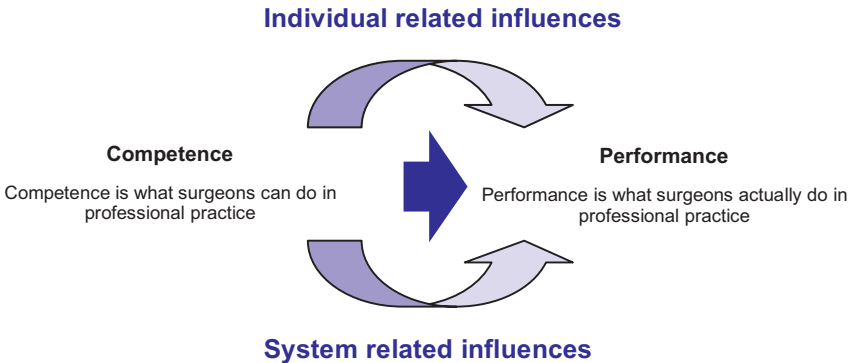


Competence and Performance

There is an important and helpful distinction between competence and performance: **Competence** is what we have been trained to do and, during training, the process of developing competence is under the supervision of the RACS Education Board. Competence therefore encompasses what we have learned and can do. That involves acquiring and maintaining skills.

Performance is about practice. It is what we actually do day to day. How we perform is influenced by a variety of abilities, some of which are technical and others are non-technical. Competence and performance are also inter-related. Figure 1 describes how surgical performance in practice is affected by system related and individual influences.

Figure 1



Adapted from Rethans et al (2002)

An example would be that the ability of a surgeon in the 21st Century to deliver best practice depends upon not only their operating ability, but also on the ability to participate as a member or leader of a multidisciplinary team. Another example is the willingness of a surgeon to participate in audit and peer review, not only to confirm their technical performance, but also to enable opportunities for improvement to be identified.

Individual related influences include personality, health and family issues.

System related influences include those that arise from the hospital or service and relate to matters such as workload, staffing, funding, competing demands for time, and resources.

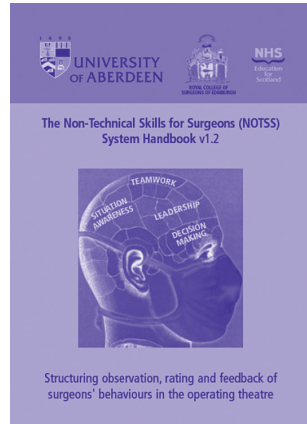


Behavioural Markers

Surgical performance in practice may be assessed through the use of Behavioural Markers.

Behavioural markers are short descriptions of good and poor behaviour that have been used to structure training and evaluation of non-technical skills in anaesthesia, civil aviation, and the nuclear power industry in order to improve safety and efficiency.

The NOTSS (Non-Technical Skills for Surgeons) program of the Royal College of Surgeons, Edinburgh and the School of Psychology at the University of Aberdeen focused specifically on the non-technical skills of surgeons in the operating room (Flin et al., 2006a). The NOTSS program identified a set of cognitive (e.g. decision making) and interpersonal (e.g. teamwork) skills that are important in the operating room environment. The program developed sets of behavioural markers under each of these headings based on cognitive task analysis with consultant surgeons, and supported by other data, including adverse event reports, observations of surgeons' behaviour in theatre, and attitudes of theatre personnel to error and safety (Flin et al., 2006b) and a literature review (Yule et al., 2006).



Category	Category rating*	Element	Element rating*	Feedback on performance and debriefing notes
Situation Awareness		Gathering information		
		Understanding information		
		Projecting and anticipating future state		
Decision Making		Considering options		
		Selecting and communicating option		
		Implementing and reviewing decisions		
Communication and Teamwork		Exchanging information		
		Establishing a shared understanding		
		Co-ordinating team activities		
Leadership		Setting and maintaining standards		
		Supporting others		
		Coping with pressure		

* 1 Poor; 2 Marginal; 3 Acceptable; 4 Good; N/A Not Applicable

1 Poor Performance endangered or potentially endangered patient safety, serious remediation is required
 2 Marginal Performance indicated cause for concern, considerable improvement is needed
 3 Acceptable Performance was of a satisfactory standard but could be improved
 4 Good Performance was of a consistently high standard, enhancing patient safety; it could be used as a positive example for others
 N/A Not Applicable

The NOTSS program also developed an assessment system whereby surgeons in the operating theatre could be rated on the basis of their exhibiting good and poor markers of behaviour. This rating can be undertaken by direct observation in the operating theatre or by review of video recordings of the operating surgeon.

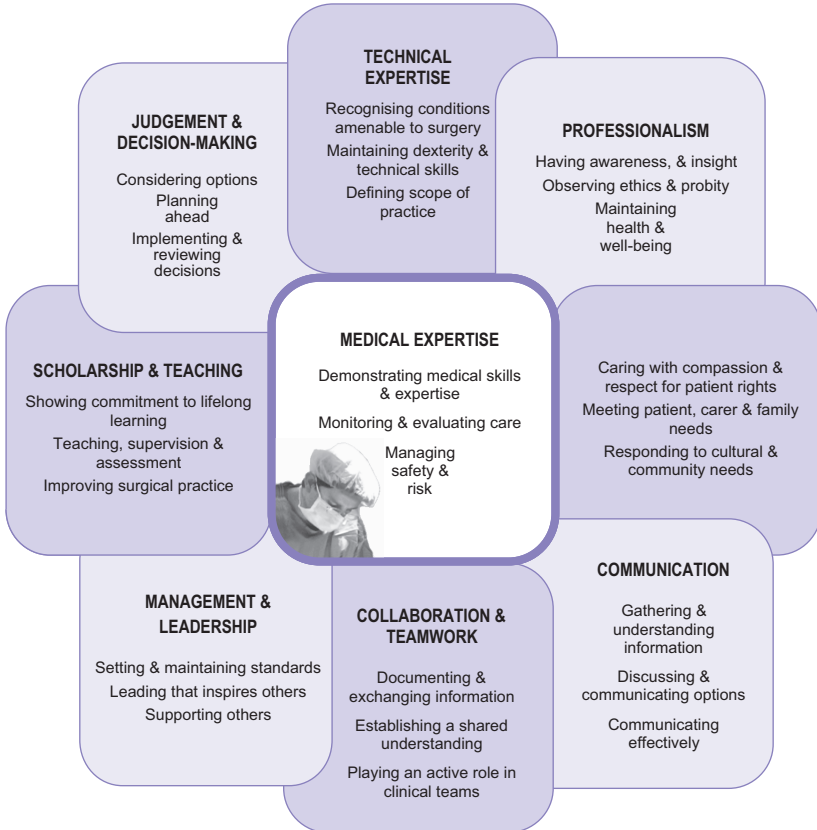
Some of the markers in this guide have been taken from the NOTSS program and this is gratefully acknowledged.



RACS Performance Framework

The Surgical Competence and Performance Working party has reviewed and expanded on the NOTSS behavioural markers to cover both non-technical and technical aspects of performance both in and outside the operating theatre, across all nine RACS Competencies.

Under each competency, three major 'patterns of behaviour' have been identified:



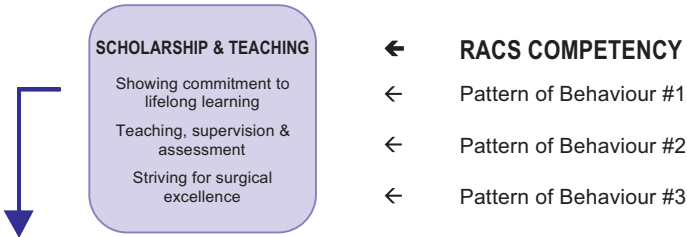
RACS behavioural markers have been developed to provide examples of good and poor behaviour under each Pattern of Behaviour.



RACS Behavioural Markers

Markers of good behaviour can provide guidance to surgeons regarding exemplary behaviour whereby they may be seen as a role model for trainees or other surgeons. Markers of poor behaviour may help to identify early evidence of underperformance and provide a basis for support and remediation of underperforming surgeons before patient safety or standards of care are compromised.

Example:



Showing commitment to lifelong learning

Engaging in a lifelong commitment to reflective learning both through their own learning and by passing on their knowledge to others.

Good behaviours

- Participates in conferences, courses and other CPD activities
- Encourages questioning by colleagues, trainees and junior medical officers

Poor behaviours

- Shows errors in understanding of literature or doesn't acknowledge recent literature
- Fails to keep up to date with current literature
- Avoids involvement in teaching, grand rounds and supervision/mentoring

It should be noted that the good and poor behavioural markers represent the extremes of surgical performance. There is a wide spectrum of normal and appropriate surgical behaviour between these extremes – the 'shades of grey' of surgical practice.

Patterns of behaviour, behavioural markers, performance measures, resources and supports are identified for each of the RACS Competencies in the pages that follow. These have been based on extensive consultation with surgical specialty societies and associations, regional committees and interviews with individual surgeons from most specialties in Australia and New Zealand. The behavioural markers do not represent an exhaustive list, but are examples of what may be considered in "good" and "poor" behaviour.



Surgical Competence and Performance

Medical Expertise

Integrating and applying surgical knowledge, clinical skills and professional attitudes in the provision of patient care.

Demonstrating medical skills and expertise

Consistently demonstrating the highest standards of medical knowledge, surgical skill and professional behaviour.

Good behaviours

- Provides a consistently high standard of pre-operative, intra-operative and post-operative care
- Ensures appropriate pain management is instituted in a timely manner
- Consistently considers the impact of co-morbidities on presentation of surgical disease or recovery from surgical intervention
- Ensures the development, implementation and evaluation of a plan of fluid and electrolyte management

Poor behaviours

- Orders inappropriate or unnecessary investigations
- Denies that surgical underperformance will directly impact on patient safety and health outcomes
- Is unresponsive to concerns regarding post-operative issues
- Fails to ensure that a clear post-operative plan is available

Monitoring and evaluating care

Regularly reviewing and evaluating clinical practice, surgical outcomes, complications, morbidity and mortality.

Good behaviours

- Participates in surgical audit and peer review
- Compares own results with: departmental peers; other surgeons in the community; and the published material
- Reviews and discusses 'problem' cases
- Participates in root cause analyses or other reviews of adverse events

Poor behaviours

- Fails to regularly attend audit meetings or audit own results
- When clearly at fault, blames others for poor outcomes
- Makes no comparisons of their work to others' results or agreed standards
- Employs new technique without an appropriate appraisal process



Managing safety and risk

Ensuring patient safety by understanding and appropriately managing clinical risk.

Good behaviours

- Always undertakes an appropriate preoperative assessment of patients
- Demonstrates awareness of unlikely but serious potential problems and prepares accordingly
- Uses appropriate aseptic techniques, including regular hand washing, to minimise the risk of infection
- Adopts safe policies to ensure correct procedure at the correct site on the correct patient is undertaken

Poor behaviours

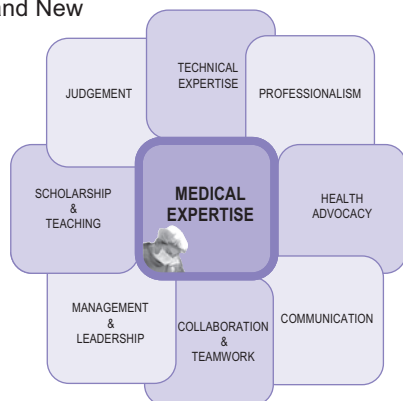
- Undertakes a hasty assessment without asking pertinent questions e.g. regarding anticoagulants
- Proceeds with surgery knowing that equipment or facilities are inadequate or not ready for safe use
- Demonstrates a lax attitude toward marking site and side of surgery
- Ignores incident reporting system

Measuring Performance

- Surgical audit and peer review
- Specialty craft group audits
- Cumulative Summation (CUSUM) techniques

Resources and Supports

- Clinical Audit – Establishing the Processes (Van Rij & Landmann, 2006)
- Guidelines for Surgical Audit in Australia and New Zealand (Watters et al 2006)
- Surgical Audit and Peer Review (RACS, 2008a)
- Guidelines for Managing an Outlier through Structured Audit Processes (RACS, 2006)
- Cumulative Sum Techniques for Surgeons: a brief review (Yap et al., 2007)



Judgement & Decision-making

Making informed and timely decisions regarding assessment, diagnosis, surgical management, follow-up, health maintenance and promotion.

Considering options

Generating alternative possibilities or courses of action to solve a problem. Assessing the hazards and weighing up the threats and benefits of potential options.

Good behaviours

- Recognises and articulates problems to be addressed
- Initiates balanced discussion of options, pros and cons with relevant team members
- Seeks second opinion when appropriate for surgeons or patients
- Respects the patient's right for self determination

Poor behaviours

- Does not consider or discuss options
- Does not solicit views of other team members
- Fails to adequately discuss and ensure documentation on the options and the basis of decision-making
- Unwilling to alter decision as other information/alternatives become available

Planning ahead

Predicting what may happen in the near future as a result of possible actions, interventions or non-intervention

Good behaviours

- Plans operating lists taking into account potential delays due to surgical or anaesthetic challenges
- Shows evidence of having a contingency plan e.g. by identifying and asking for equipment that may be required
- Makes decisions clearly in a timely manner
- Identifies the level of post-operative care that will be required and ensures that facilities are appropriate

Poor behaviours

- Does not consider the views of operating room or other relevant clinical staff
- Does not help team prepare for predictable or likely events
- Fails to issue post-operative instructions to staff
- Is difficult to contact and admonishes staff for continued attempts to make contact



Implementing and reviewing decisions

Undertaking the chosen course of action and continually reviewing its suitability in light of changes in the patient's condition. Showing flexibility and changing plans if required to cope with changing circumstances to ensure that goals are met.

Good behaviours

- Implements decisions within an appropriate timeframe
- Reconsiders plan in light of changes in patient condition or when problem occurs
- Calls for assistance if required
- Routinely follows up investigation results and surgical specimen pathology

Poor behaviours

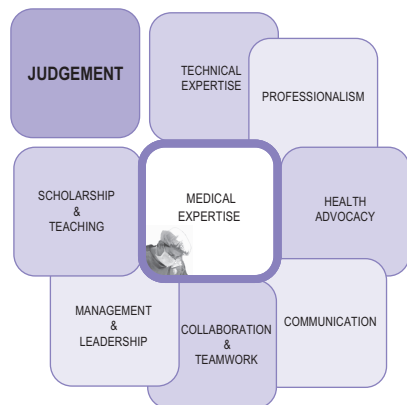
- Frequently fails to implement decisions
- Makes same error repeatedly
- Continues with initial plan in face of predictably poor outcome or when there is evidence of a better alternative
- Becomes hasty or rushed

Measuring Performance

- Multisource feedback particularly from trainees, junior staff, departmental staff and members of the operative team
- High fidelity simulation exercises
- Video observation (Including NOTSS)
- Script Concordance Analysis

Resources and Supports

- RACS Courses:
 - Care of the Critically Ill Surgical Patient (CCrISP)
 - Early Management of Severe Trauma (EMST)



Technical Expertise

Safely and effectively performing appropriate surgical procedures.

Recognising conditions amenable to surgery

Demonstrating an understanding of when surgical intervention is or is not indicated.

Good behaviours

- Consults with peers and colleagues when management is unclear
- Routinely questions and justifies approaches to surgical problems and all aspects of practice
- Prioritises need for surgery appropriately in emergency and elective situations
- Recognises when further assessment, observation or investigation is preferable to immediate surgery

Poor behaviours

- Focuses on the surgical dimension without seeking advice on the management of non surgical co-morbidities
- Chooses most aggressive procedure without regard for the condition of the patient
- Performs surgery inappropriately or prematurely given the patient's diagnosis or current condition
- Will not discuss justification for any decisions

Maintaining dexterity and technical skills

Consistently demonstrating sound surgical skills at a level appropriate to a surgeon's experience and the nature of the patient's condition.

Good behaviours

- Goes through appropriate processes when learning a new technique e.g. visiting surgical expert or mentoring
- Participates in simulation exercises and other evaluations of technical skills when appropriate
- Modifies clinical practice in response to ageing, impairment or limitation of manual dexterity
- Uses techniques that minimise the risk of needle stick injury for surgeon, assistants and other staff

Poor behaviours

- Hurries assessment of new procedures and resents input of others
- Introduces new technology or procedures without consultation and planning
- Denies the impact of ageing or physical impairment on manual dexterity or technical skills
- Carelessly handles surgical instruments or equipment



Defining scope of practice

Undertaking surgery appropriate to a surgeon's training and expertise as well as the available facilities, conditions and staffing.

Good behaviours

- Takes into account local hospital conditions and support services in defining scope of practice
- Knows own limitations and when to ask for help, referring conditions outside their usual scope to colleagues
- Calls for help when facing a difficult problem outside of competence
- Modifies scope of practice in accordance with current experience

Poor behaviours

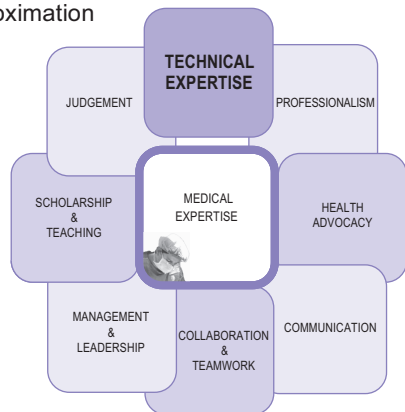
- Carries on when would clearly benefit from help of others
- Fails to refer appropriately or in a timely manner
- Lacks insight of own surgical capabilities, undertaking procedures not experienced in or better handled elsewhere
- Takes on cases beyond scope of training when colleagues are available for referral

Measuring Performance

- Surgical audit and peer review
- Specialty craft group audits
- High fidelity (Virtual Reality) simulation
- Video recording and review

Resources and Supports

- RACS Course
 - Advanced Minimal Access Surgery – An advanced skills workshop for surgeons interested in minimal access tissue approximation techniques
- General Guidelines for Assessing, Approving & Introducing New Procedures into a Hospital or Health Service (RACS/ASERNIP-S, 2008b)



Professionalism

Demonstrating commitment to patients, the community and the profession through the ethical practice of surgery.

Having awareness and insight

Reflecting on an individual's surgical practice and having insight into its implications for patients, colleagues, trainees and the community.

Good behaviours

- Adopts a courteous approach to other staff and patients
- Responds positively to questioning, suggestion and objective criticism
- Admits to errors
- Recognises poor outcomes and the need to reflect and improve

Poor behaviours

- Stubborn, refuses help when it is clearly required
- Blames registrars or others for poor outcomes
- Books inappropriately long lists or is misleading with theatre staff/anaesthetists regarding length of operations
- Berates or humiliates subordinates

Observing ethics and probity

Maintaining standards of ethics, probity and confidentiality and respecting the rights of patients, families and carers.

Good behaviours

- Provides an ethical role-model for other staff
- Ensures that prior to commencement all research projects are reviewed and approved by a research ethics committee
- Carefully explains sensitive or invasive examinations or treatment to the patient and seeks informed consent before carrying them out
- Maintains appropriate personal and sexual boundaries with patients at all times

Poor behaviours

- Makes questionable claims for medical benefits, insurance, third party or workers compensation payments
- Exhibits bullying, harassing or sexist attitudes towards trainees, other staff or patients
- Breaches confidentiality by discussing patient details in public areas
- Blames a patient for their own professional transgressions



Maintaining health and well-being

Maintaining personal health and well-being and considering the health and safety needs of colleagues, staff and team members.

Good behaviours

- Has a personal general practitioner and attends regularly and appropriately
- Has regular rest and holidays
- Enquires after the welfare of colleagues and junior staff
- Enjoys leisure activities and interests outside surgery

Poor behaviours

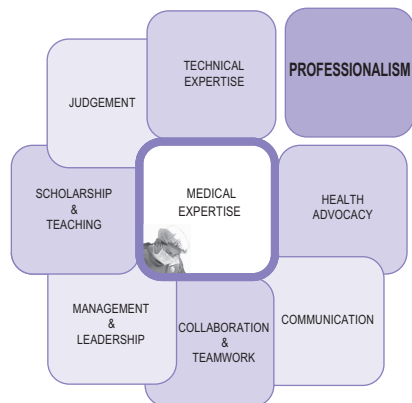
- Uses alcohol indiscriminately eg when on call or prior to performing elective surgery
- Abuses prescription medications or uses illegal drugs
- Regularly exhibits moodiness or dispirited behaviour
- 'Battles on' even when unwell or overtired without recognising the impact on surgical performance

Measuring Performance

- Multisource Feedback
- Patient satisfaction survey

Resources and Supports

- Surgical professionalism in the 21st century (McCulloch, 2006)
- Professionalism in Medicine (CMA, 2001)
- Code of Conduct (RACS (2006b)
- Informed Financial Consent (RACS, 2006c)
- Preparation for Practice: A Guide for Younger Fellows (RACS, 2007)
- Understanding Doctors Harnessing Professionalism (Levenson et al, 2008)



Health Advocacy

Responding to the health needs and expectations of individual patients, families, carers and communities.

Caring with compassion and respect for patient rights

Providing optimum care while respecting patients' rights, choice, dignity, privacy and confidentiality.

Good behaviours

- Encourages patients to seek different views or opinions and to exercise choice
- Treats patients courteously and compassionately, engaging them in decision-making and respecting their choices
- Exhibits concern and respect for patients' privacy
- Is willing to spend further time with distressed patient to listen to their concerns

Poor behaviours

- Delegates the process of informed consent to inexperienced juniors
- Gives the impression of being 'heartless' or lacking in empathy or concern for the patient
- Disregards patients' need for self-esteem and privacy
- Spends insufficient time with a patient, particularly in an emotionally charged situation

Meeting patient, carer and family needs

Engaging patients and, where appropriate, families or carers in planning and decision-making in order to best meet their needs and expectations.

Good behaviours

- Plans investigations and treatment taking into account the needs of the patient firstly, and carers
- Ensures appropriate communication with family members concerning plans and outcomes of surgery
- Follows up referred patients and seeks reports on progress
- Allows sufficient time for the patient to express concerns or misgivings regarding the course of treatment

Poor behaviours

- Cancels theatre lists at short notice without adequate reason
- Inappropriately delegates tasks to junior staff in order to avoid dealing with difficult problems
- Undertakes an inadequate or incomplete assessment in the context of a patient's physical or cognitive disability
- Fails to ensure that track of patients waiting for surgery is kept



Responding to cultural and community needs

Demonstrating understanding of the impact of culture, ethnicity and spirituality on surgical care and considering the broader health, social and economic needs of the community.

Good behaviours

- Strives to improve access to health care services
- Recognises wider health needs of community in an under-resourced system
- Contributes to community education and development
- Communicates effectively with people from culturally and linguistically diverse backgrounds and uses interpreters

Poor behaviours

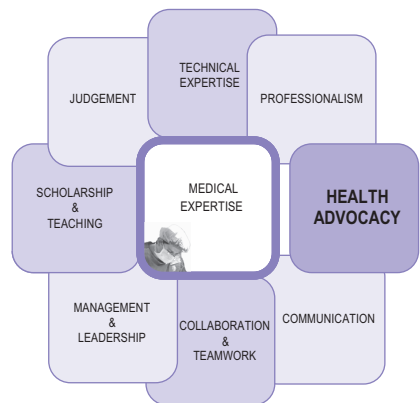
- Disregards community impact of decisions
- Shows no interest in community engagement
- Insensitive to different patients' backgrounds cultural beliefs or attitudes
- Discriminates on the basis of culture, ethnicity or religion

Measuring Performance

- Multisource Feedback, particularly from patients, carers and families
- Patient satisfaction survey

Resources and Supports

- The Australian Medical Association has a range of publications relating to public health issues (AMA – Public Health, 2008)
- The Australian Resource Centre for Healthcare Innovation (ARCHI) has a number of educational resources on cultural competency (ARCHI, 2007)
- The Health Issues Centre is an organisation that aims to improve the health outcomes of Australians, and has a range of publications relating to advocacy (Health Issues Centre)



Communication

Communicating effectively with patients, families, carers, colleagues and other staff in order to form an accurate picture of the clinical situation and plan accordingly.

Gathering and understanding information

Seeking timely and accurate information during the consultation, in the ward or clinic and in the operating room.

Good behaviours

- Ensures that all relevant documentation, including notes, results and consent, are available and have been reviewed
- Reflects on and discusses significance of information
- Liaises with anaesthetist regarding anaesthetic plan and asks anaesthetist for regular updates during operation
- Ensures that ongoing patient condition is monitored during procedure (e.g. blood loss)

Poor behaviours

- Fails to review relevant information collected by team
- Does not ask for results until the last minute
- Does not discuss potential problems
- Frequently asks for information to be read from patient notes because has not been read before operation started

Discussing and communicating options

Discussing options with patients and communicating decisions clearly and effectively.

Good behaviours

- Reaches a decision and clearly communicates it
- Makes provision for and communicates other options and plans
- Informs patient, family and relevant staff about the expected clinical course for each patient
- Is decisive and has clear goals and plans of management

Poor behaviours

- Fails to inform team of surgical plan
- Is aggressive or unresponsive if plan questioned
- Selects inappropriate manoeuvres often leading to complications
- Appears to make it up as she/he goes and is angered when difficulties are encountered



Communicating effectively

Exchanging information with patients, families, carers, colleagues and other staff.

Good behaviours

- Follows up test results and communicates them to patient
- Encourages the surgical team to ask questions
- Demonstrates empathy and compassion when breaking bad news
- Shows awareness and sensitivity to patients from different cultural backgrounds

Poor behaviours

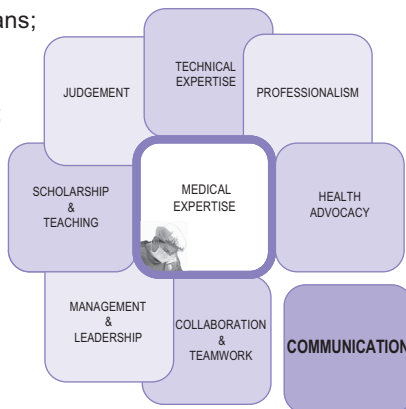
- Is discourteous to staff or patients
- Frequently talks in technical jargon to patients and doesn't check for adequate understanding
- Routinely interrupts or dismisses the comments of patients, families, colleagues or staff
- Shows insensitivity to the impact of language, culture or disability on communication

Measuring Performance

- Multi-Source Feedback, particularly from patients and colleagues
- Patient satisfaction survey
- Medical record audit
- Review of letters, discharge summaries and other forms of written communication
- Calgary-Cambridge Observation Guide (Kurtz, 2003)
- Kalamazoo Essential Elements: The Communication Checklist (Makoul, 2001a)
- Video observation (Including NOTSS)

Resources and Supports

- RACS Courses:
 - Communication Skills for Cancer Clinicians;
 - Mastering Difficult Communications Master class;
 - Mastering Intercultural Communications;
 - Mastering Professional Interactions
- Calgary-Cambridge Guide to the Medical Interview – Communication Process (Kurtz, 2003)
- The SEGUE Framework for Teaching & Assessing Communication Skills (Makoul, 2001b)



Collaboration & Teamwork

Skills for working in a team context to ensure that the surgical team has an acceptable shared picture of the clinical situation and can complete tasks effectively.

Documenting and exchanging information

Giving and receiving knowledge and information in a timely manner to aid establishment of a shared understanding among team members.

Good behaviours

- Is collegiate and professional in dealings with members of department and practice
- Listens to, discusses and appropriately acts upon concerns of team and staff members
- Considers other points of view in difficult situations
- Records contemporaneous and legible notes regarding patient management

Poor behaviours

- Does not listen to team members or practice staff
- Needs help from assistant/staff member but does not make it clear what assistant is expected to do
- Refuses to accept clinical opinions of others
- Fails to ensure provision of timely information to patients' referring doctor or general practitioner

Establishing a shared understanding

Ensuring that the team has all necessary and relevant clinical information, understands it and that an acceptable shared 'big picture' view is held by members.

Good behaviours

- Provides briefing, clarifies objectives and ensures team understands the operative plan before starting operation
- Ensures that relevant staff know the projected management plan for the patient
- Encourages input from members of the team
- Debriefs relevant team members, discussing what went well and problems that occurred

Poor behaviours

- Fails to do regular ward rounds or initiate collective discussion and review of patient progress
- Fails to keep anaesthetist informed about procedure (e.g. to expect bleeding)
- Appears uncomfortable discussing the operative plan if challenged
- Does not take into account suggestions made from hospital staff or practice staff



Playing an active role in clinical teams

Working together with other team members to carry out cognitive and physical activities in a simultaneous, collaborative manner.

Good behaviours

- Discusses anticipated admissions with management team
- Stops operating when asked to by anaesthetist or scrub nurse
- Informs surgical team of changes in management
- Arrives in a timely fashion to ensure start time not delayed by surgeon's lateness

Poor behaviours

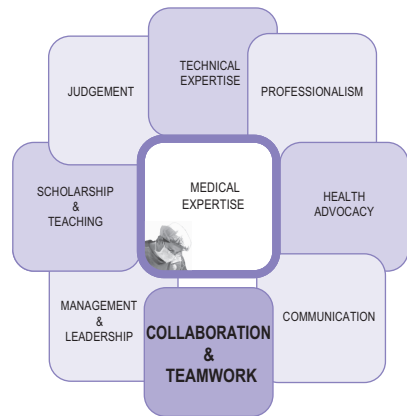
- Proceeds with operation without ensuring that equipment is ready
- Fosters disharmony or conflict in the patient care team
- Becomes combative when asked to reduce lists to fit available session time
- Doesn't tell practice staff of changed consultation availability

Measuring Performance

- Multisource feedback particularly from colleagues and members of the operative team
- High fidelity simulation exercises involving team management of surgical cases
- Video observation (Including NOTSS)

Resources and Supports

- RACS Courses:
 - Mastering Professional Interactions; From the Flight Deck: Improving Team Performance
- The Leadership and Management of Surgical Teams (Giddings & Williamson, 2007)
- The Australian Commission on Safety and Quality in Health Care National Patient Safety Education Framework 'Being a team player and showing leadership' (ACSQHC, 2008)



Management & Leadership

Leading the team and providing direction, demonstrating high standards of clinical practice and care, and being considerate about the needs of team members.

Setting and maintaining standards

Supporting safety and quality by adhering to acceptable principles of surgery, following codes of good clinical practice, and following hospital and theatre protocols.

Good behaviours

- Introduces self to new or unfamiliar members of surgical or practice team
- Clearly follows hospital, operating theatre and ward and practice protocols
- Requires all team members to observe standards (e.g. sterile field, professionalism of staff in clinic or practice)
- Always prepared to give a considered opinion on medical aspects of a management issues

Poor behaviours

- Fails to observe standards or protocols (e.g. continues even though equipment may be contaminated)
- Shows disrespect to patients or staff
- Dismisses the opinions of colleagues from other clinical disciplines
- Demonstrates disorganisation and chronic lateness

Leading that inspires others

Retaining a calm demeanour when under pressure and emphasising to the team that he/she is under control of a high-pressure situation. Adopting a suitably forceful manner if appropriate without undermining the role of other team members.

Good behaviours

- Remains calm under pressure, working methodically towards effective resolution of difficult situations
- Resolves team conflicts quickly and appropriately
- Acts as a role-model to others in both technical and non-technical areas of surgery
- Continues to provide leadership in critical situations

Poor behaviours

- 'Freezes' and displays inability to make decisions under pressure
- Fails to refer case when unexpected technical challenge requires other expertise
- Blames others for errors and does not take personal responsibility
- Loses temper repeatedly or inappropriately; has tantrums or throws instruments



Supporting others

Providing cognitive and emotional help to team members. Judging different team members' abilities and tailoring one's style of leadership accordingly.

Good behaviours

- Provides constructive criticism to team members
- Ensures delegation of tasks is appropriate
- Establishes rapport with team members
- Gives credit for tasks performed well

Poor behaviours

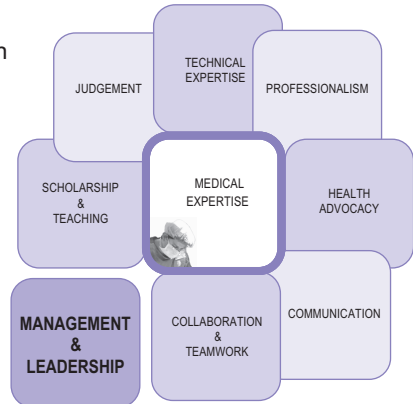
- Does not provide recognition for tasks performed well
- Fails to recognise needs of others
- Shows hostility to other team members e.g. makes sarcastic comments to nurses or junior medical staff
- Puts down junior staff or other hospital workers

Measuring Performance

- Multisource feedback particularly from trainees, junior staff, departmental staff and members of the operative team
- High fidelity simulation exercises involving management of crisis situations
- Video observation (Including NOTSS)

Resources and Supports

- RACS Courses:
 - Surgeons as Managers;
 - Practice Management for Practice Managers
- Support for surgeons regarding leadership and management of surgical teams is often best provided by colleagues in similar positions in equivalent sized hospitals or practices e.g. in discussion groups or journal clubs
- The Leadership and Management of Surgical Teams (Giddings & Williamson, 2007)
- NHS Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement, 2007)



Scholarship & Teaching

As scholars and teachers, surgeons demonstrate a lifelong commitment to reflective learning, and the creation, dissemination, application and translation of medical knowledge.

Showing commitment to lifelong learning

Engaging in a lifelong commitment to reflective learning both through their own learning and by passing on their knowledge to others.

Good behaviours

- Participates in regularly conferences, courses and other CPD activities
- Encourages questioning by colleagues, trainees and junior medical officers
- Engages with staff and encourages their learning, development and career planning
- Demonstrates understanding of the recent literature and demonstrates impact of this on clinical and office practice

Poor behaviours

- Shows errors in understanding of literature or doesn't acknowledge recent literature
- Fails to keep up to date with current literature
- Avoids involvement in teaching, grand rounds and supervision/mentoring
- Demonstrates no interest in the training and development of junior staff

Teaching supervision & assessment

Facilitating education of their students, patients, trainees, colleagues, other health professionals and the community.

Good behaviours

- Provides continuous constructive feedback without personalising the issues
- Provides adequate supervision to junior staff
- Uses clinical encounters as an opportunity for teaching of staff
- Makes themselves available for planned lectures and tutorials

Poor behaviours

- Demonstrates arrogance, rudeness or disinterest in the training of junior staff
- Fails to delegate appropriately to junior staff
- Regularly fails to attend scheduled tutorials and other teaching sessions
- Is critical of a junior staff member even when staff could not reasonably be expected to know



Improving surgical practice

Evaluating or researching surgical practice, identifying opportunities for improvement and implementing change at individual, organisational and health system levels.

Good behaviours

- Strives to improve surgical practice through research, innovation and audit of outcomes
- Actively promotes best practice and evidence-based surgery principles
- Alters practice if clinical performance is shown to be suboptimal
- Always looks for better solutions to improve care

Poor behaviours

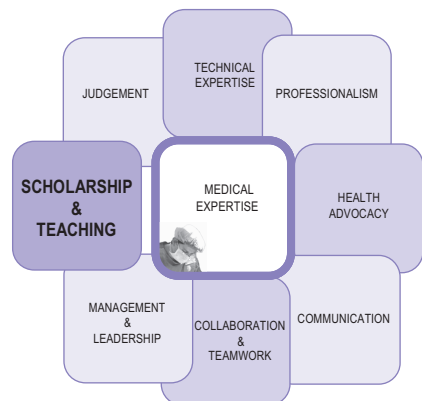
- Ignores the evidence-base regarding emerging surgical technologies and techniques
- Promotes a 'it works for me, therefore it is right' approach in the absence of appropriate evidence
- Ignores research and ethics approval requirements for studying new surgical practices or conducting clinical trials
- Fails to inform patient when a procedure is innovative or new

Measuring Performance

- Multi-Source Feedback, particularly from trainees and students
- Records of conferences and courses attended
- Annual accrual of Continuing Professional Development (CPD) points
- Reports and synopses of conferences, seminars and courses
- Feedback from review of manuscripts for publication, grant applications and research ethics proposals
- Personal learning portfolios
- Feedback and evaluation of teaching sessions
- Evaluation and follow-up of personal and organisational improvement activities

Resources and Supports

- RACS Courses:
 - Surgical Teachers Course;
 - Supervisors Course (SATSET);
 - Polishing Presentation Skills;
 - Critical Literature Evaluation and Research (CLEAR);
 - Statistics for Surgeons Workshop.
- RACS CPD On-line service
- 'Teaching on the Run' programs
- University Medical Education and Research courses



Assessment Tools

Assessing performance is different from assessing competence, and there is a variety of tools available for the assessment of surgical competence and performance.

Many surgeons will be familiar with assessment tools used at undergraduate and surgical trainee levels and which focus on the assessment of competence. These are typically used as part of a 'high stakes' examination during undergraduate or Surgical Education and Training, and many will have been involved in using these assessment tools with their trainees. Examples of some of the tools that are used to assess competence are Multiple Choice Questions (MCQ), Objective Structured Clinical Examination (OSCE), Short Answer Questions (SAQ), Direct Observation of Procedures - Surgical (DOPS), Mini Clinical Evaluation Exercise (MiniCEX) and written tests (essay questions) (Banderiera G, et al., 2006).

With practising surgeons, the aim is to measure performance in the nine surgical competencies and most surgeons perform well across all areas. However, when there is a question about a surgeon's performance, it frequently relates to problems in several different areas of competence.

Self assessment

One of the purposes of this guide is to present examples in all competencies for a surgeon to assess their own performance against examples of good behaviour. Whilst there is obviously benefit in this, it does require insight into the issues of less than acceptable performance that the individual recognises and seeks to correct.

Through completion of the annual College CPD Recertification Data Form, surgeons also maintain a record (log) that demonstrates their commitment to lifelong learning. This record, in combination with the self assessment described above provides a valuable aid to reflection on competence and performance.

Assessment by others

The aim of training is to ensure that a trainee has knowledge and skills in all competencies, and one role of the trainers and supervisors is to assess their competence and performance in each area. When performance is considered to be below the expected level, the issue can be discussed in a non-judgemental, open and fair manner. This will involve verifying the facts by talking to a number of people, including the surgeon concerned and reviewing all the evidence. It is also important to be aware of any bias, 'spin', interpretations or assumptions that may have been made.

Addressing the surgeon who is underperforming is more difficult but needs to follow a similar process. Confidentiality, a non-judgemental supportive approach, the unbiased opinions of peers and reference to explicit examples of the underperformance are integral to achieving a successful change in behaviour.



Examples of assessment tools that are likely to be useful in reviewing practising surgeons are described below.

Surgical audit and peer review

The College requires that all surgeons who undertake operative procedures are required to participate in an annual peer-reviewed audit. Outcome audit measures surgical performance, particularly in the areas of medical and technical expertise and of clinical judgement and decision-making. It is the systematic, critical analysis of the quality of surgical care that is reviewed by peers against explicit criteria or recognised standards, and then used to further inform and improve surgical practice. The sorts of questions that we might have to answer from audit are:

- Is the management of Condition A consistent with the current literature and evidence-based practice?
- Does Surgeon B follow the standard treatment guidelines?
- Are the outcomes of Operation C acceptable?
- Are the investigations ordered appropriate?

Further information about audit is available in *Surgical Audit and Peer Review* (RACS 2008)

Performance review

There is potential benefit of a routine annual performance review provided that it follows an agreed format and content across all competencies, that it involves the Director of Surgery, and that it is not used to denigrate surgeons. Performance review implies agreeing what performance is expected prior to the period being reviewed. Therefore each surgeon must be engaged and agree to the process prior to the review period.

Review of complaints and adverse incidents

In practice, a review of a complaint or adverse incident is currently the most commonly used assessment tool. It usually relates to an individual surgeon and occurs following a perceived incident of poor performance. Most hospitals have mechanisms for dealing with these reviews, and further information is contained in the College policies *Clinical Standards Review* and *Complaints Process*.

Case review

Case review is a form of audit that is typically undertaken when a surgeon's performance is questioned, but when there is no specific complaint or incident. Approximately 20 individual cases are reviewed either within a specific area of performance or across a range of surgical competences. This method is limited by what is documented and depends on agreeing the appropriate management plan beforehand from the clinical information and investigations available. A number of cases can be reviewed to determine aggregates (i.e. audit) but individual cases can also be reviewed to look at specific processes and whether these processes are being followed (including documentation).



Multi-source feedback

Multi-source feedback (including 360 degree feedback) is the process whereby assessment of aspects of performance can be made by a range of colleagues (department heads, medical directors, peers, registrars, nursing and other staff) and/or patients. Done in a comprehensive and sensitive manner, multi-source feedback can provide valuable information, but it can be time consuming. An approach is to break down the process into components that may include:

- Supervision and support for junior staff and trainees
- Teamwork – feedback from clinical team members including radiologists, anaesthetists and nurses (ward, theatre and outpatient)
- Communication – can be assessed by observing a clinical (or non-clinical) interaction or by asking patients about how they felt their surgeon communicated with them
- Management and leadership – organisation and setting standards can be assessed by peers and staff
- Direct observation, for example of a procedure by an independent assessor or peer. This may be appropriate if there were a specific problem to address and the surgeon recognises there is a problem, struggles to understand the full extent or nature of the problem and is willing to ask a colleague to join him/her to give constructive criticism and comment.
- Patient satisfaction surveys

Specific surgical competencies

The behavioural markers outlined in this handbook provide a guide across the nine surgical competencies about the standards of good behaviour that are recognised as 'aspirational', together with examples of poor behaviours that may indicate the need for remediation or support.



Support for Surgeons

The College encourages all surgeons to recognise and discuss the challenges facing them and to ensure that self care is part of managing professional life.

Self Care

Self care involves taking care of your physical, mental and emotional health. It also involves eating, sleeping and living well. To ensure surgeons enjoy their work and leisure, priorities and boundaries need to be set.

Surgeons are at risk from stress, burnout and a range of illnesses. We have a responsibility to be alert to our symptoms and to seek appropriate professional care as patients.

The publication *Keeping the Doctor Alive: A Self Care Guide for Medical Practitioners* is a valuable resource, available through the Department of Professional Standards. Fellows who complete the exercises in the guidebook are eligible to claim one point per hour in Category 7: Other Professional Development of the RACS Continuing Professional Development (CPD) Program.

Telephone: +61 3 9249 1274 Email: college.cpd@surgeons.org

Website: <http://www.racgp.org.au/publications/tools#9>

Consult your General Practitioner

Surgeons are encouraged to regularly visit a General Practitioner they trust to manage their health care. Encourage your colleagues to do the same. By allowing another doctor to objectively manage your health, you will be free to do what you do best - concentrate on the health of your patients.

Support Networks and Surgical Friends

Maintaining an effective support network is recognised by many specialties in many countries as being the single most important means by which medical practitioners can maintain balance and health in their lives. Support networks can include surgical department heads and peers, colleagues, structured support networks and personal support from family and friends.

Many surgeons find it invaluable to select one or two 'surgical friends' who are available to help and support in stressful times. This arrangement is best made proactively before specific incidents or trouble occurs.



Strengthening your Skills

There are a number of professional development opportunities and tools available that promote and strengthen skills for managing the challenges and pressures of surgical practice. These include time and practice management skills, coping with stress and burnout, conflict resolution and self care strategies for the healthy doctor.

Peer Support Networks

The College encourages Specialty Societies and hospital departments to establish structured peer network programs to support surgeons, including support after an adverse event. The following are examples of professional peer support services available to surgeons:

Australia

Professional Peer Support Network

The Royal Australian College of General Practitioners and *beyondblue*, in conjunction with a range of other Medical Colleges offer a structured peer program designed by medical practitioners for medical practitioners. Doctors meet together in small groups at regular intervals to provide support to each other to meet the needs for professional, social and emotional support and to engender a culture of self-care.

Telephone: +61 3 86990574 Email: ppsp@racgp.org.au

New Zealand

Support for Surgeons Group - Royal Australasian College of Surgeons

The Support for Surgeons Group consists of fifteen surgeons from a range of specialties trained in counselling available to support colleagues feeling isolated, stressed, experiencing health issues or need a peer to talk with.

Telephone: +64 4 385 8247 Email: college.nz@surgeons.org

For more information on surgeons' health, professional development opportunities and tools to support surgeons please visit the College website: www.surgeons.org/SupportforSurgeons.

Australia and New Zealand

Members at Risk Program - Urological Society of Australia and New Zealand

The Members at Risk Program consists of two Personal Assistance Panels of senior, discreet Urologists who can confidentially assist members experiencing surgical and personal difficulties before more serious issues occur. The program is available for members who need help and also for those members who believe a colleague may need help. The Personal Assistance Panel members have published their email and mobile contact details for direct approaches.

Telephone: +61 2 9362 8644 Website: www.urosoc.org.au



Need more help?

RACS Executive Director of Surgical Affairs

The Executive Director of Surgical Affairs is a Fellow of the College and plays an important role in assisting surgeons with a range of issues including advice on re-entry to practice and re-skilling, and is also a contact point to discuss concerns.

Dr John Quinn (Australia) Telephone: +61 3 9249 1206

Mr John Simpson (New Zealand) Telephone: + 64 4 385 8247

RACS Regional Committees

Regional Committees, consisting of RACS Fellows, are available to assist Fellows with local support and advice.

ACT Regional Committee

Telephone: + 61 2 6285 4023

Email: college.act@surgeons.org

NSW Regional Committee

Telephone: + 61 2 9331 3933

Email: college.nsw@surgeons.org

SA Regional Committee

Telephone: + 61 8 8239 1000

Email: college.sa@surgeons.org

QLD Regional Committee

Telephone: + 61 7 3835 8600

Email: college.qld@surgeons.org

TAS Regional Committee

Telephone: + 61 3 6223 8848

Email: college.tas@surgeons.org

VIC Regional Office

Telephone: + 61 3 9249 1255

Email: college.vic@surgeons.org

WA Regional Committee

Telephone: +61 8 6488 8699

Email: college.wa@surgeons.org

NZ National Board

Telephone: + 64 4 385 8247

Email: college.nz@surgeons.org



Doctors' Health Advisory Services

Doctors' health advisory services provide independent, confidential support and medical advice to doctors.

- ACT:** Colleague of First Contact (24hr)
Telephone: +61 2 6270 5410 Helpline: +61 407 265 414
- NSW:** Doctors' Health Advisory Service (24hr)
Telephone: +61 2 9902 8135 Helpline: + 61 2 9437 6552
Website: www.doctorshealth.org.au
- NT:** Doctors' Health Advisory Service
Telephone: +61 8 8927 7004
- SA:** Doctors' Health Advisory Service (24hr)
Telephone: +61 8 8222 5501 Helpline: +61 8 8273 4111
- QLD:** Doctors' Health Advisory Service
Telephone: +61 7 3822 2222 Helpline: +61 7 3833 4352 (24hr)
- TAS:** AMA Doctors Help Line (24hr)
Helpline: +61 3 6223 2047 After hours: +61 3 6235 4165
- VIC:** Victorian Doctors Health Program (24hr)
Telephone: +61 3 9495 6022 Email: vdhp@vdhp.org.au
- WA:** Colleague of First Contact (24hr)
Telephone: +61 8 9273 3033 Helpline: +61 8 9321 3098
- NZ:** Doctors' Health Advisory Service
Helpline: +64 4 471 2654

Australian Medical Association (AMA) Telephone Assistance

Victoria Peer Support Service - 1300 853 338

Rural Support

Australia: The Bush Crisis Line and Support Services: 1800 805 391 (24hr)

Lifeline:

Australia: Telephone: 13 11 14



Other Services

Alcoholics Anonymous

Australia:

Telephone: +61 2 9599 8866

Website: www.aa.org.au

New Zealand:

Telephone: 0800 229 675

Website: www.alcoholics-anonymous.org.nz

Alcohol and Drug Information

Australia:

Telephone: 1800 198 024 (24hrs)

Website: ADIS@health.wa.gov.au

Alcohol Drug Helpline

New Zealand:

Telephone: 0800 787 797 (10am – 10pm)

Website: www.adanz.org.nz

Narcotics Anonymous

Australia:

Telephone: 1800 652 820

Website: www.naoz.org.au

New Zealand:

Website: www.nanz.org

Australian Hearing

Telephone: + 61 2 9412 6800

Website: www.hearing.com.au

Hearing Association New Zealand

Telephone: + 64 4-939 6754

Website: www.hearing.org.nz

Vision Australia

Telephone: +61 2 9599 8866

Website: www.visionaustralia.org.au

Surgeons are also encouraged to seek counsel from within their community (e.g. local community and church services).



Appendix 1

Surgical Competence & Performance Working Party

The Surgical Competence and Performance Working Party (SCPWP) reported to the Professional Development and Standards Board (PDSB), chaired by Dr Ian Dickinson. The PDSB reports to Council.

The SCPWP comprised the following members:

Dr Ian Dickinson, Chair and Orthopaedic surgeon QLD
Professor Guy Maddern, General surgeon SA
Dr Mark Edwards, Cardiothoracic surgeon WA
Professor Andre van Rij, General surgeon NZ
Assoc Professor Peter Woodruff, Vascular surgeon QLD
Dr John Graham, Vascular surgeon NSW
Professor David Watters, General surgeon VIC
Assoc Professor Jenepher Martin, General surgeon VIC
Professor Michael Grigg, Vascular surgeon VIC
Mr Patrick Alley, General surgeon NZ
Mr Simon Williams, Orthopaedic surgeon VIC
Mr Andrew Roberts, Vascular surgeon VIC
Mr Gary Speck, AMA representative and Orthopaedic surgeon VIC
Dr Chris Cain, AMA representative and Orthopaedic surgeon SA
Assoc Professor Julian Rait, MIIAA representative and Ophthalmologist VIC

Dr John Quinn, RACS Executive Director of Surgical Affairs, Australia
Mr John Simpson, RACS Exec. Director of Surgical Affairs, New Zealand
Professor John Collins, RACS Dean of Education
Dr Pam Montgomery, RACS Director, Fellowship and Standards
Dr Ian Graham, RACS Project Manager (SED Health Consulting)
Dr Wendy Crebbin, RACS Manager, Education Development & Research

Contributions have also been made by many other individual Fellows. We gratefully acknowledge all of them.



Appendix 2

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[www.rcplondon.ac.uk/professional-Issues/Documents/Understanding-doctors \(Kingsfund\)-FINAL.pdf](http://www.rcplondon.ac.uk/professional-Issues/Documents/Understanding-doctors (Kingsfund)-FINAL.pdf)

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