Royal Australasian College of Surgeons

2022 VICTORIA STATE ELECTION

Election Issues

Introduction

The Royal Australasian College of Surgeons (RACS) was established in 1927 and is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. RACS is a not-for-profit organisation representing more than 8,300 surgeons and 1,300 surgical Trainees across nine surgical specialties. Approximately 95 per cent of all surgeons practicing in New Zealand and Australia are Fellows of the College (FRACS).

The Victorian State Committee represents nearly 2000 of this surgical cohort across Victoria.

RACS is committed to ensuring the highest standard of safe and comprehensive surgical care for the communities it serves and, as part of this commitment, strives to take informed and principled positions on issues of public health.

Prior to all government elections in Australia and Aotearoa New Zealand, RACS outlines areas of specific concern and relevance to the delivery of surgical services. We then provide an opportunity for political parties to outline their policy positions on these key issues relevant to the delivery of surgical services and distribute these responses to our membership and the public.

KEY ISSUES

The RACS Victorian State Committee (VSC) has identified **five** key focus areas that are relevant to our members, the Victorian surgical community, in the 2022 Victorian state election:

1. **Essential and planned surgery waiting lists**
2. **Surgical reform**
3. **Infrastructure and surgical technology**
4. **Protection of the title 'surgeon'**
5. **Victorian Audit of Surgical Mortality and Victorian Perioperative Consultative Council**

Background information on these key areas follows, and RACS would like to receive your party's responses to the questions posed.

1. Essential surgery waiting lists

The VSC recognises that surgeons are at the precipice of the pressures faced by health care systems. They understand the continuing and increasing demands for specialist surgical care and access to surgery as they work to clear the enormous backlog of patients on surgical waiting lists. The current model where surgeons and allied staff work excessive hours in an effort to chip away at these lists is unsustainable and unsafe. Novel and innovative solutions should be sought in addressing this issue.

The ongoing effects of Covid-19 has placed extraordinary pressure on essential and planned surgery in Victoria. While the VSC commends the appointment of a Chief Surgical Advisor, the establishment of the Surgical Recovery and Reform Taskforce, and the recent acquisition of two private hospitals, these actions alone will not solve the problems faced by the healthcare sector.

Health services' ability to improve living standards through surgery is increasing. However, the allocation of resources to support this remains suboptimal. The extensive backlog of approximately 98,000 people on surgical waiting lists could take many years to progress. This has a compounding effect on community health as patients' wait for primary care access, and specialty consultation continue to grow. It is essential that the next government documents and makes transparent a multiprong approach to a broader reform to address these factors.

While the impact of COVID-19 has played a significant role in growing the backlog, the continued stop-start of elective surgery compounds the issue. The expanding surgical waiting lists preceded the pandemic and reflected many issues and underfunding complicit in previous models. An overall increase in health investment is essential to manage the allocation of resources to ensure equitable and expedient access to comprehensive healthcare for all patients.

Access for trainees to surgical cases is essential in ongoing training. While we support the various models involving the engagement of private hospitals in managing public patients, this also presents issues for surgical trainees, with a lack of access to treating disease states hampering and delaying their learning and training.

Q. Will your party commit to ensuring supply and resources in addressing the lengthening surgical waitlist be maintained and increased according to demand? Will your party provide a transparent and detailed suite of novel and innovative ideas to manage the detrimental growing essential surgical waiting lists while ensuring safe hours are maintained for the surgical community and ensuring that the next generation of surgeons are adequately taught?

2. Surgical reform

The task of reforming the Victorian healthcare sector is substantial. The complexities and the interconnected nature of the Victorian healthcare sector means that reform cannot be applied to only one sector without due consideration of many other facets. The effects of COVID-19 have compounded these issues. While several discussions are in place to reform health care, the Victorian State Committee calls on the next government to implement immediate sustainable change, producing transparent short and long-term goals that will be measured and ensuring success in providing access to timely and safe patient care.

2.1 Surgery as part of universal healthcare

Surgery is an essential component of universal health care. The next government needs to work to preserve and deliver this care. However, as surgery is linked inexorably with all other branches in the sector, the overall provision of healthcare, from primary care, allied health, multidisciplinary pain and rehabilitation to aged care and childcare, must be addressed. The resolution of “bottlenecks” in these fields will ensure an adequate and expedient flow of patients through the surgical field towards a successful outcome.

Expedient management of new crises will also aid in the community's uninterrupted provision of surgical care. No longer can there be a stop-start approach to surgery. Preparation must be foremost in the development of any healthcare reforms. Should another pandemic or disaster arise, a more robust and sustainable model needs to be developed within the healthcare sector.

The various current models of public in private and public by private care of patients are welcomed but cannot remain the long-term solutions. Issues with insurance and equitable provision have plagued this model. If this approach is retained as part of a broader suite of changes, then these issues need to be addressed and resolved to ensure that surgical care providers are appropriately protected and that patients are safely managed.

2.2 Workforce

The next Victorian government must look at investment in systems that retain current health workers, advance the knowledge of existing workers and attract new staff. Educating the next generation of health workers is also vital in growing the workforce. A safe and rewarding environment must be created to provide support, protection and flexibility to health workers. Continuing

Substantial investment in accredited surgical training posts is essential to grow the number of surgeons, which is a robust and coveted program. Over the last three years, the number of accredited training posts has been static. As the Victorian population grows, so does the demand for surgical care. A static number of surgeons and staff cannot meet this demand.

Fundamental employment rights must be provided in retaining health workers and surgeons. Any employee in any sector is entitled to work in a safe and supported environment. Abuse and disrespect toward the health community is growing and may reflect the scourge that is spreading in our society. The protection of our health workers is vital in retaining our current staff. Further, other rights, including the right to take annual leave, access to flexible working arrangements and job security, for example, will show the employees that the sector values their dedication, devotion and skill and hopefully result in greater retention of experienced and expert staff.

RACS, with other medical colleges, has developed a Wellbeing Charter for doctors. The principles are transferable across the health workforce, being that the well-being of the health workers enables them to care for others. It takes a broad support network to ensure that this is achieved. The fundamental principles of the Wellbeing Charter include:

- Maintaining wellbeing leads to the performance of high-quality and effective healthcare delivery and optimises patient care.
- Doctors who maintain and maximise their health and wellbeing are able to manage the physical and emotional demands of medicine.
- Wellbeing is essential to achieving the competencies required for good medical practice.
- Wellbeing benefits the individual and the medical community in which doctors work.
- Jurisdictions, hospitals and medical colleges must support the wellbeing of doctors and provide an environment that is safe, accessible and inclusive for all.

On a more specific note, one change may be the incorporation of primary benefits to assist staff to feel supported in their work by transferring leave entitlements across hospitals and jurisdictions. This is particularly important for surgical trainees and would provide greater flexibility for both male and female trainees towards building flexible training models into everyday practice.

2.3 Rural workforce

For too long, regional and rural communities have been an afterthought when considering modification and changes to healthcare delivery. In addressing issues associated with the rural workforce, we need to build a surgical workforce that reflects the communities in which we serve to deliver better outcomes for patients. With an increase in the regional population over recent years, investment in health systems must be distributed across the state in terms of long-term infrastructure development and provisions for rewarding and equitably remunerated jobs. This will attract people to work in regional areas. A contributor to this is investment in post-Fellowship training places in regional areas. Affordable housing for this workforce would also ease the burden for these workers.

Q: How does your party plan to build the future surgical workforce to address Victoria's growing population and health needs as outlined?

Q: Will you work with hospitals and health services to create an environment conducive to safe and flexible training for surgical trainees?

Q. What actions will your party implement to ensure the well-being of the current and future health workforce?

Q. How will your party address the inequality in the provision of surgical healthcare for the rural community?

3. Infrastructure and surgical technology

3.1 Maintenance of Surgical Facilities

Surgery has developed and progressed exponentially due to increasing demands from a growing population. Life expectancy is, rightly, increasing with the overall health and well-being of the community at an all-time high. Surgical treatments have been leading this successful outcome. However, resources to maintain this world's best practice are proportionately dwindling. The increasing demands will never be met without maintaining the current surgical output. It is vital that the status quo first be supported with increasing provisions of supply before any advancement is considered.

Before any increase in activity is considered, the lack of resources and some duplication and wastage must be addressed. The pandemic highlighted issues that were already present. The overworked and under-resourced healthcare sector and the surgical community have had to work with little in order to maintain, quite correctly, the demands for excellence in healthcare from the public. Duplication of practices has meant wasting resources that could have been funnelled to other needy fields. Lack of conformity or standardisation in certain practices, including a standard radiology platform in the public hospital system, for example, has meant delays, missed opportunities or duplication that have impacted patients' lives. The benefits of advanced technologies can only be fulfilled if basic healthcare can be achieved.

3.2 Robotic surgery and advancing technologies

Across Australia and internationally, surgical specialties are adopting new technologies, and the evidence increasingly demonstrates benefits to patients and cost savings for health systems. As the demand for minimally invasive robotic surgery and other technologies grow and the capabilities of the technology increase, it is vital that an adequate surgical service delivery model be devised to ensure that the highest quality of care is available to **all** patients in the appropriate setting.

To date, most robotic surgical systems in Victoria and Australia sit within the private sector. We feel that such technology should be available where appropriate to **all** patients, irrespective of the ability of patients to pay. The VSC recognises the investment for robot-assisted surgery at Ballarat Hospital. However, these investments must be ensured broadly across all metropolitan and regional health services.

RACS has recently entered into an agreement with the International Medical Robotics Academy (IMRA) to develop training pathways in robotic-assisted surgery (RAS). This program enables RACS to influence the direction of training and, with IMRA, set the standards for RAS competence and contribute to high-quality training for all robotics approved for use within the surgical sector. Further, this will enable RACS to contribute at a leadership level to the credentialing, practice and continuing professional development of future and current Fellows of RACS.

We would encourage the next Victorian Government to continue its investment in such systems in the public hospital sector to ensure access to all and allow training opportunities that will complement the RACS program.

Q. How will your party ensure that resources and supplies vital to the safe and uninterrupted function of healthcare facilities are maintained?

Q. What will your party do to ensure public patients have access to the highest quality surgical technology?

4. Use of the title ‘surgeon’

Protecting the public by restricting the title ‘surgeon’ to those with accredited advanced surgical training

RACS welcomes the recent announcement from the federal health minister regarding restricting the use of the term surgeon. RACS calls on the next Victorian government to continue to advocate for this change to ensure the provision of surgical care to the Victorian public is provided by appropriately trained practitioners.

Background
In Australia, the title ‘surgeon’ has not been restricted despite many other specialty titles under the Health Practitioner Regulation National Law being so. This means that many doctors who have not completed Australian Medical Council accredited training in surgery can advertise themselves using the term ‘surgeon’. This term invokes a sense of expertise, safety and ethically justified knowledge in the public. The inappropriate use of this term is misleading and, as evidenced by several case studies, may lead to patient harm.

RACS surgical training programs, completed over five or more years, provide surgical trainees with skills that extend beyond just ‘cutting’. The RACS surgical Competence and Performance standards have formed the foundation for all RACS Fellows and incorporate a broad range of technical, non-technical and professional skills deemed essential to practice at the highest level of proficiency and patient care. The vigorous and in-depth nature of the training programs prepares the surgeon for ethical decision-making, preparation for surgical treatment and, importantly, deal and manage unexpected complications.

With the focus squarely on patient safety, RACS’ considered position is that only those registered in specialties for which the relevant Australian Medical Council (AMC) accredited training program includes a significant surgical component at a sufficient standard should be able to use ‘surgeon’ in their titles.

RACS continues to advocate this issue at a state and federal level to protect the public and maintain public confidence in our health system. Australians rightly expect all surgical procedures to be performed to the highest possible standards. They expect those carrying out procedures to meet nationally established educational standards, undertake regular training and continued education, and be registered in an appropriate specialty. Restricting the title in the way RACS proposes would meet the Australian public’s expectations and guarantee that people advertising themselves using ‘surgeon’ in their titles have the necessary physiological, ethical, psychological, pharmacological and medical training and experience to diagnose, treat and manage surgical patients safely.

RACS Fellows comprehensively care for the whole patient; from the diagnosis to counselling, advice, and development of a treatment plan that may – or may not involve a surgical procedure, ensuring that alternatives to a proposed treatment are discussed and that if surgery is to proceed that the practitioner is the best suited and trained to perform that procedure, either by themself or as part of a wider more comprehensive team. This approach would also allow the surgeon to care for the patient effectively post-operatively and deal with complications in a manner that safeguards patients.

RACS is concerned about reports of patients suffering adverse outcomes when elective cosmetic surgery is performed by medical practitioners advertising themselves as cosmetic surgeons, but who do not have specialist registration in a surgical discipline. As the COAG Health Council noted in 2019, the lack of regulation of the term ‘surgeon’, ‘can cause confusion among members of the public’. The public does not view cosmetic surgery as “risk-taking”, but some of it is. There have been numerous cases of patients suffering adverse outcomes, having undergone surgery by non-surgical specialist practitioners. Restricting who can use ‘surgeon’ in this way would help prevent patients from undergoing surgery under an incorrect assumption about the quality and standard of training of the person carrying out the surgery. It would also help maintain public confidence in the high standards of our health system.

Q14: Does your party support legislative change to protect the title of ‘surgeon’, and if so, will you commit to working with other Australian governments to ensure this is successful?

5. Victorian Audit of Surgical Mortality and Victorian Perioperative Consultative Committee

The Victorian Audit of Surgical Mortality (VASM) forms part of the Australian and New Zealand Audit of Surgical Mortality (ANZASM)—a national network of regionally-based audits of surgical deaths that aim to ensure the highest standards of safe and comprehensive surgical care. VASM is a collaboration between the Victorian Government's Department of Health and the Royal Australasian College of Surgeons (RACS). The College manages VASM through its Melbourne office.

VASM, like its inter-jurisdictional counterparts, monitors trends and reviews all cases where patients have died while under the care of a surgeon via independent peer-review assessments. These assessments identify clinical management issues for which strategies can be developed to manage and improve patient safety.

All private and public hospitals that provide surgical services participate in the audit, and participation by RACS surgeons is compulsory as part of their annual continuing professional development requirement.

All surgery carries some risk, and it is an unfortunate reality that sometimes patients do not survive surgery or die after having a surgical procedure. The majority of these deaths are not preventable and occur despite surgery to overcome a life-threatening condition. In some instances, however, death is an unexpected outcome of surgery for a condition that is not life-threatening. It is essential that the issues surrounding death in the latter group are studied to see if similar adverse outcomes can be prevented.

By assessing surgical deaths in Victoria, the audit can provide hospitals and the government feedback on systemic issues within the public and private sectors. This is an independent approach in a qualified privilege environment.

In a broader field, the VPCC was created to review further not only the mortality trends in surgery but the issues that may arise in the perioperative domain. To further reduce the risk of harm to the community, the VPCC is tasked with reviewing and advising on best practices when dealing with morbidity associated with the delivery of surgical care. Together VASM and VPCC play a vital role in ensuring that harm to patients receiving surgical care is reduced. As part of both entities' charter, a strong educational component is delivered in order to educate the surgical community and the broader public on ways to avoid and prevent risk and harm in a learned manner.

Q: The mortality audit program is part of an effective quality assurance activity to improve surgical care. The perioperative consultative committee aims to monitor, review and advise on matters in the operative and perioperative sphere to maintain the safe and efficient provision of surgical care to the community. RACS seeks a commitment from your party that support and funding of these entities will continue.