A GUIDE BY
THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL COMPETENCE
AND PERFORMANCE

RACS
Competence
& RACS
Performance

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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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TABLE OF CONTENTS

INTRODUCTION ............................................................................................................. 2
RACS COMPETENCIES ................................................................................................ 2
COMPETENCE & PERFORMANCE ............................................................................... 3
BEHAVIOURAL MARKERS ........................................................................................... 4
RACS PERFORMANCE FRAMEWORK ....................................................................... 5
RACS BEHAVIOURAL MARKERS ................................................................................ 6
SURGICAL COMPETENCE & PERFORMANCE ......................................................... 7
Medical Expertise ...................................................................................................... 7
Judgement & Decision-making ................................................................................. 9
Technical Expertise ................................................................................................. 11
Professionalism ....................................................................................................... 13
Health Advocacy ..................................................................................................... 15
Communication ....................................................................................................... 17
Collaboration & Teamwork ..................................................................................... 19
Management & Leadership .................................................................................... 21
Scholarship & Teaching .......................................................................................... 23

ASSESSMENT TOOLS ................................................................................................ 25
SUPPORT FOR SURGEONS ...................................................................................... 28
NEED FURTHER HELP? ............................................................................................. 30
APPENDIX 1 - Surgical Competence and Performance Working Party .................... 33
APPENDIX 2 - References ........................................................................................... 34
References cont’d.


Van Rij A, Landmann M (2006) Clinical Audit – Establishing the Processes, Clinical Audit & Outcomes Research Unit, Department of Surgery, Dunedin School of Medicine, University of Otago, Dunedin New Zealand.


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 Jenipher 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.

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
- Heath 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

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.

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.we.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).
**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).

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:

- **JUDGEMENT & DECISION-MAKING**
  - Considering options
  - Planning ahead
  - Implementing & reviewing decisions

- **SCHOLARSHIP & TEACHING**
  - Showing commitment to lifelong learning
  - Teaching, supervision & assessment
  - Improving surgical practice

- **MANAGEMENT & LEADERSHIP**
  - Setting & maintaining standards
  - Leading that inspires others
  - Supporting others

- **MEDICAL EXPERTISE**
  - Demonstrating medical skills & expertise
  - Monitoring & evaluating care
  - Managing safety & risk

- **TECHNICAL EXPERTISE**
  - Recognising conditions amenable to surgery
  - Maintaining dexterity & technical skills
  - Defining scope of practice

- **PROFESSIONALISM**
  - Having awareness, & insight
  - Observing ethics & probity
  - Maintaining health & well-being

- **COMMUNICATION**
  - Gathering & understanding information
  - Discussing & communicating options
  - Communicating effectively

- **COLLABORATION & TEAMWORK**
  - Documenting & exchanging information
  - Establishing a shared understanding
  - Playing an active role in clinical teams

- **JUDGEMENT & DECISION-MAKING**
  - Considering options
  - Planning ahead
  - Implementing & reviewing decisions

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

**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 6223 8848
  - 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
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

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:

**SCHOLARSHIP & TEACHING**

<table>
<thead>
<tr>
<th>RACS COMPETENCY</th>
<th>Pattern of Behaviour #1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching, supervision &amp; assessment</td>
<td>Pattern of Behaviour #1</td>
</tr>
<tr>
<td>Striving for surgical excellence</td>
<td>Pattern of Behaviour #3</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Good behaviours</th>
<th>Poor behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides a consistently high standard of pre-operative, intra-operative and post-operative care</td>
<td>Orders inappropriate or unnecessary investigations</td>
</tr>
<tr>
<td>Ensures appropriate pain management is instituted in a timely manner</td>
<td>Denies that surgical underperformance will directly impact on patient safety and health outcomes</td>
</tr>
<tr>
<td>Consistently considers the impact of co-morbidities on presentation of surgical disease or recovery from surgical intervention</td>
<td>Is unresponsive to concerns regarding post-operative issues</td>
</tr>
<tr>
<td>Ensures the development, implementation and evaluation of a plan of fluid and electrolyte management</td>
<td>Fails to ensure that a clear post-operative plan is available</td>
</tr>
</tbody>
</table>

**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.

**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.
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)

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.
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

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).
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)

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) (Bandiera 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.
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
Scholarship & Teaching

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

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
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Measuring Performance

- Surgical audit and peer review
- Specialty craft group audits
- High fidelity (Virtual Reality) simulation
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- General Guidelines for Assessing, Approving & Introducing New Procedures into a Hospital or Health Service (RACS/ASERNIP-S, 2008b)

Teaching supervision & assessment

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

**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

**Good behaviours**
- Provides continuous constructive feedback without personalising the issues
- Provides adequate supervision to junior staff
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- 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
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
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- Puts down junior staff or other hospital workers

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- Multisource feedback particularly from trainees, junior staff, departmental staff and members of the operative team
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- **RACS Courses:**
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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

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 e.g. 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

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:
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  - 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)
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

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)
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- 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
- Kalamazoo Essential Elements: The Communication Checklist (Makoul, 2001a)
- Video observation (Including NOTSS)

Resources and Supports

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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
- Stubbbon, 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

Supporting others

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

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Scholarship & Teaching

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

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

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
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- General Guidelines for Assessing, Approving & Introducing New Procedures into a Hospital or Health Service (RACS/ASERNIP-S, 2008b)
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

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

**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

**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
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)
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).
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)

**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.

**Multi-source feedback**
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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

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.

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

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- Employs new technique without an appropriate appraisal process
**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

**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.
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:

- **JUDGEMENT & DECISION-MAKING**
  - Considering options
  - Planning ahead
  - Implementing & reviewing decisions

- **SCHOLARSHIP & TEACHING**
  - Showing commitment to lifelong learning
  - Teaching, supervision & assessment
  - Improving surgical practice

- **MEDICAL EXPERTISE**
  - Demonstrating medical skills & expertise
  - Monitoring & evaluating care
  - Managing safety & risk

- **COLLABORATION & TEAMWORK**
  - Documenting & exchanging information
  - Establishing a shared understanding
  - Playing an active role in clinical teams

- **TECHNICAL EXPERTISE**
  - Recognising conditions amenable to surgery
  - Maintaining dexterity & technical skills
  - Defining scope of practice

- **PROFESSIONALISM**
  - Caring with compassion & respect for patient rights
  - Meeting patient, carer & family needs
  - Responding to cultural & community needs

- **COMMUNICATION**
  - Gathering & understanding information
  - Discussing & communicating options
  - Communicating effectively

- **MANAGEMENT & LEADERSHIP**
  - Setting & maintaining standards
  - Leading that inspires others
  - Supporting others

- **RACS – The College of Surgeons of Australia and New Zealand**

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

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 6223 8848
  - 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
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).

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.

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

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

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
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.

![Diagram](image)

**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.

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.we.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).
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).
Appendix 2

References


ARCHI (2007) Australian Resource Centre for Healthcare Innovation
www.archi.net.au


www.cma.ca/multimedia/staticContent/HTML/N0/l2/discussion_papers/professionalism/pdf/professionalism.pdf


www.rcseng.ac.uk/publications/docs/leadership_management.html/attachment_download/pdfffie
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>2</td>
</tr>
<tr>
<td>RACS COMPETENCIES</td>
<td>2</td>
</tr>
<tr>
<td>COMPETENCE &amp; PERFORMANCE</td>
<td>3</td>
</tr>
<tr>
<td>BEHAVIOURAL MARKERS</td>
<td>4</td>
</tr>
<tr>
<td>RACS PERFORMANCE FRAMEWORK</td>
<td>5</td>
</tr>
<tr>
<td>RACS BEHAVIOURAL MARKERS</td>
<td>6</td>
</tr>
<tr>
<td>SURGICAL COMPETENCE &amp; PERFORMANCE</td>
<td>7</td>
</tr>
<tr>
<td>Medical Expertise</td>
<td>7</td>
</tr>
<tr>
<td>Judgement &amp; Decision-making</td>
<td>9</td>
</tr>
<tr>
<td>Technical Expertise</td>
<td>11</td>
</tr>
<tr>
<td>Professionalism</td>
<td>13</td>
</tr>
<tr>
<td>Health Advocacy</td>
<td>15</td>
</tr>
<tr>
<td>Communication</td>
<td>17</td>
</tr>
<tr>
<td>Collaboration &amp; Teamwork</td>
<td>19</td>
</tr>
<tr>
<td>Management &amp; Leadership</td>
<td>21</td>
</tr>
<tr>
<td>Scholarship &amp; Teaching</td>
<td>23</td>
</tr>
<tr>
<td>ASSESSMENT TOOLS</td>
<td>25</td>
</tr>
<tr>
<td>SUPPORT FOR SURGEONS</td>
<td>28</td>
</tr>
<tr>
<td>NEED FURTHER HELP?</td>
<td>30</td>
</tr>
<tr>
<td>APPENDIX 1 - Surgical Competence and Performance Working Party</td>
<td>33</td>
</tr>
<tr>
<td>APPENDIX 2 - References</td>
<td>34</td>
</tr>
</tbody>
</table>

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RACS (2008a) Royal Australasian College of Surgeons - Surgical Audit and Peer Review. Third ed. [www.surgeons.org](http://www.surgeons.org)


Van Rij A, Landmann M (2006) Clinical Audit – Establishing the Processes, Clinical Audit & Outcomes Research Unit, Department of Surgery, Dunedin School of Medicine, University of Otago, Dunedin New Zealand.


A GUIDE BY
THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL COMPETENCE
AND PERFORMANCE

RACS
Competence
& RACS
Performance