



Royal Australasian College of Surgeons  
The College of Surgeons of Australia and New Zealand

# Surgical Competence and Performance

**A guide to aid the assessment and  
development of surgeons**

*Academic Scholarship and Teaching*  
*Management and Leadership*  
*Collaboration and Teamwork*  
*Judgement and Decision-Making*  
*Medical Expertise Professionalism*  
*Communication Health Advocacy*

# Foreword

The College is committed to fostering the highest standards of surgical care and professional behaviour. Being a surgeon carries a responsibility for participation in lifelong learning, and a willingness to monitor performance in the workplace.

To aid these processes, and to complement the existing College Continuing Professional Development (Recertification) Program, Council identified the need to develop better processes for assessing surgical performance. The work was undertaken by the Performance Assessment Steering Committee during 2010 and 2011, under the governance of the Professional Development and Standards Board.

The first edition of the Surgical Competence and Performance Guide (June 2008) described a framework to assess the performance of practising surgeons. The Guide was widely circulated, but little used except where it provided a tool for surgical department heads and hospital managers to address underperformance. Yet it was always intended to be an aspirational guide that encouraged all surgeons to reflect on their performance as they read and re-read it. This second edition of the Guide is still intended to promote reflection, learning and improvement. However, this edition also includes a performance assessment and feedback tool that is able to be used for self-reflection, or given to colleagues and co-workers for peer review or multi-source (360 degree) feedback. It is designed for the benefit of all surgeons not just for those whose performance is under scrutiny.

It is important that surgeons provide input and leadership to the development and evaluation of tools and processes to assess surgical performance. For those tasked with providing feedback to surgeons on their performance, some principles are provided in the 'Providing Constructive Feedback' section on page 9 of this Guide. There are also a number of courses which provide an opportunity for further training in feedback and appraisal. These courses are available through healthcare organisations and Continuing Professional Development programs.

Funding to assist with the development of this revised Guide and the Performance Assessment and Feedback Tool was provided by the Medical Indemnity Industry Association of Australia, Avant Insurance and MDA National Insurance. The College is grateful for this support.

We encourage all Fellows of the College to read this Guide and to share the Performance Assessment and Feedback Tool with peers and surgical colleagues as an opportunity for reflection and improvement. Your colleagues will benefit from your honest assessment and feedback just as you will benefit from theirs. Comments on how the Guide and tool might be improved are welcomed.



Prof David Watters FRACS  
**Chair, Performance Assessment  
Steering Committee**



Mr Ian Civil FRACS  
**President**

# TABLE OF CONTENTS

INTRODUCTION .....	2
RACS COMPETENCIES .....	2
COMPETENCE & PERFORMANCE .....	3
BEHAVIOURAL MARKERS .....	4
RACS PERFORMANCE FRAMEWORK .....	5
RACS BEHAVIOURAL MARKERS .....	6
ASSESSING THE PERFORMANCE OF SURGEONS .....	7
WHO SHOULD PERFORM THE ASSESSMENT? .....	8
AVOIDING BIAS WHEN MAKING ASSESSMENTS .....	8
PROVIDING CONSTRUCTIVE FEEDBACK .....	9
SURGICAL COMPETENCE & PERFORMANCE .....	10
Medical Expertise .....	10
Judgement & Decision-making .....	12
Technical Expertise .....	14
Professionalism .....	16
Health Advocacy .....	18
Communication .....	20
Collaboration & Teamwork .....	22
Management & Leadership .....	24
Scholarship & Teaching .....	26
ASSESSMENT TOOLS .....	28
SUPPORT FOR SURGEONS .....	31
NEED FURTHER HELP? .....	33
APPENDIX 1 - Surgical Competence and Performance Working Party .....	36
APPENDIX 2 - References .....	37



# Introduction

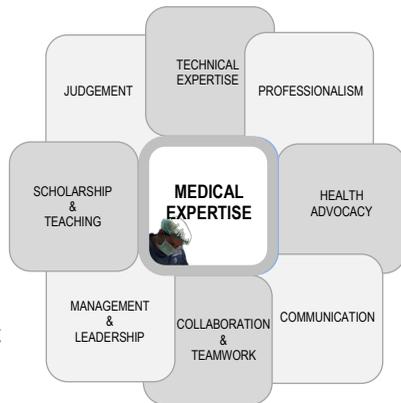
This Surgical Competence and Performance Guide presents a framework for assessing performance of practising surgeons in all areas of surgical practice and across all of the defined College competencies.

The Guide provides a tool that can be used to assess performance and provides information on resources that may support a surgeon who is concerned about underperformance. These are listed under each competency though some are relevant to more than one of the nine competencies.

## RACS Competencies

In 2003, after consultation with the fellowship and the surgical specialty societies, the College identified nine competencies of a surgeon. These competencies underpin all aspects of fellowship training and also provide the framework to assess the performance of practising surgeons. The College training and development programs contribute to certifying/recertifying surgeons across these nine competencies:

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



Each competency is vitally and equally important to the achievement of the highest standards of surgical performance (Collins et al., 2007).



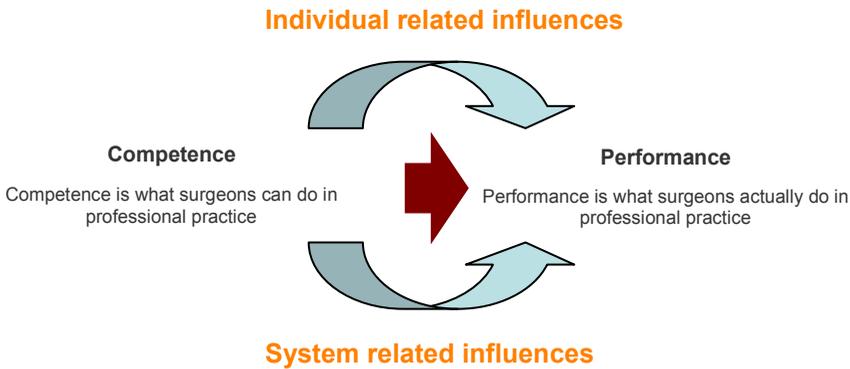
# Competence and Performance

There is an important distinction between competence and performance:

**Competence** is what we have been trained to do. 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 technical and non-technical knowledge, skills and attitudes.

**Performance** is what we actually do in day to day practice. How we perform depends on our competence but is also influenced by individual and system related factors. Figure 1 illustrates the relationship between competence and performance and shows how surgical performance in practice is affected by system related and individual influences.

Figure 1



*Adapted from Rethans et al (2002)*

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

Individual related influences include personality, health and family issues.

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



# Behavioural Markers

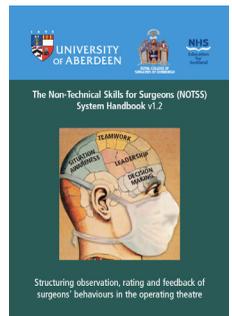
Surgical performance may be assessed in practice through the use of Behavioural Markers.

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) system of the Royal College of Surgeons, Edinburgh and the School of Psychology at the University of Aberdeen focuses specifically on the non-technical skills of surgeons in the operating room (Flin et al., 2006a).

The NOTSS system identifies four categories (situation awareness, decision-making, communication & teamwork, and leadership) that encompass a set of cognitive and interpersonal 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 following grid is used to assess the performance of surgeons in the operating room according to the identified NOTSS criteria.



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

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

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

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

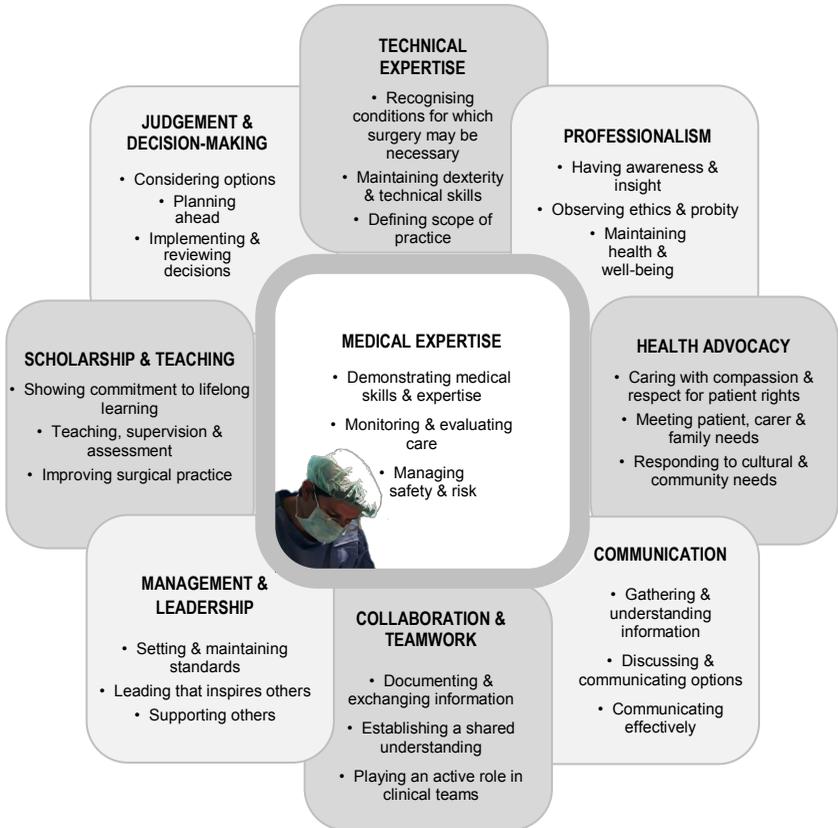
RACS has piloted NOTSS courses in 2011 and the program will now be made available across Australia and New Zealand.



# RACS Performance Framework

The first Surgical Competence and Performance Working Party 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' were identified:



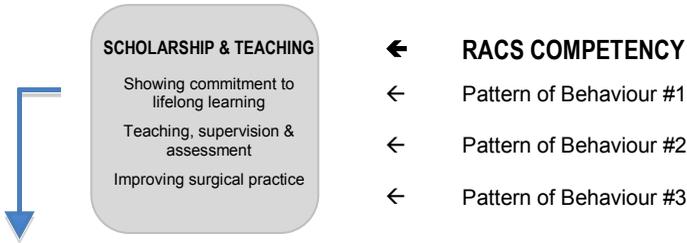
RACS behavioural markers have been developed to provide examples of good and poor behaviour under each Pattern of Behaviour.



# RACS Behavioural Markers

Markers of good behaviour can provide guidance to surgeons whereby they may be seen as a role model for trainees or other surgeons. Markers of poor behaviour may be suggestive 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.

### *Examples of poor behaviours*

- Fails to adjust practice according to current evidence
- Demonstrates critical errors in understanding of evidence available from current literature
- Shows little interest in participating in journal clubs, grand rounds and/ or clinico-pathological meetings
- Demonstrates apathy towards training and development of junior staff

### *Examples of good behaviours*

- Participates regularly in conferences, courses and other CPD activities
- Willing to reconsider current practice and to embrace change when based on sound evidence
- Engages with staff and encourages their learning, development and career planning
- Demonstrates awareness of the recent literature and considers implications for clinical and office practice

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, resources and supports are identified for each of the RACS Competencies in the pages that follow. These were originally developed for the first edition of the Guide after 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 to represent ‘good’ and ‘poor’ behaviour.



# Assessing the Performance of Surgeons

The Surgical Competence and Performance Guide can also be used as a tool to assess the performance of individual surgeons. It can be used for self-assessment (as an aid to reflection and professional development); peer assessment (between surgical colleagues); multi-source feedback (360 degree assessment involving colleagues, other staff and patients); and trainee assessment by supervisors.

In order to support these assessment processes, a rating scale is included under each of the three 'Patterns of Behaviour' that are described for each RACS Competency. Although examples of good and poor behavioural markers are provided to assist with the rating process a global assessment of the pattern of behaviour is sought.

## Recognising conditions for which surgery may be necessary

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

### Examples of poor behaviours

- Focuses on the surgical procedure without adequate consideration of non-surgical options
- Inappropriately chooses most aggressive procedure without regard for the condition of the patient
- Performs surgery prematurely or inappropriately given the patient's diagnosis or current condition
- Will not discuss justification for any decisions

### Examples of good behaviours

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

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---

Under each RACS Competency, there is also a space for writing a comment regarding the surgeon's overall performance in this domain:

<b>Comment regarding this RACS Competency</b>	(Required if any Poor or Marginal ratings have been given, otherwise optional)
<div style="border: 1px solid black; height: 40px;"></div>	



# Instructions

1. Read the descriptions of the patterns of behaviour related to each RACS Competency.
2. Consider the examples of poor and good behaviours that illustrate the global pattern of behaviour (examples only - not an exhaustive list).
3. When assessing someone else, if you are unable to rate the pattern of behaviour by direct observation, tick 'Unable to Rate'.
4. Rate the individual's behaviour using the four point scale. Please provide a comment regarding overall performance under each competency, particularly if you have given any poor or marginal ratings.

## Who should perform the Assessment?

A self-assessment can be performed across all of the RACS Competencies and patterns of behaviour. However, peer assessors and multi-source feedback raters (including patients) may only be able to comment on a subset of patterns of behaviour that are relevant to and observable by the rater.

A subset of the patterns of behaviour able to be rated by patients will need to be developed in the future. Patients would be unable to rate the majority of patterns of behaviour in the current Guide and may be overwhelmed by the process.

## Avoiding Bias when Making Assessments

Although the assessor must be someone who knows the surgeon well enough to be able to comment on their performance, there are many advantages to ensuring their assessment is provided anonymously. This enables the rater to assess without fear of repercussions or offence, potentially resulting in a more robust assessment. However anonymity may also reduce the accountability of raters for accurate and meaningful responses (Antonioni & Woehr, 2001). These factors should be taken into account when designing and implementing assessment processes and training assessors.

The following potential sources of bias or error in ratings should also be considered (Flin et al. 2009):

*Halo effect* - one particular positive aspect is overemphasised and enhances the ratings for other patterns of behaviour

*Horns effect* - one particular negative aspect is overemphasised and diminishes the ratings for other patterns of behaviour

*Leniency* - tendency to give favourable (higher) ratings

*Severity* - tendency to give unfavourable (lower) ratings

*Primacy* - remembering better/over-weighting behaviours that were observed first

*Recency* - remembering better/over-weighting behaviours that were observed last



# Providing Constructive Feedback

Self, peer and multi-source or 360 degree assessments can all contribute to the improvement of practice and professional development of surgeons. It is vitally important that the results of performance assessments are fed back to surgeons in a respectful, constructive and sensitive manner and provide a basis for continuous improvement and professional development.

Good feedback should:

- Be timely - as soon as is practicable after the rating is performed. Don't give feedback at times when you or your surgical colleague are tired or in an emotionally charged situation.
- Be specific - refer to the specific patterns of behaviour or RACS Competencies when discussing both good and poor performance.
- Be constructive - help to provide solutions for areas that require attention. The positive critique which looks at 'what can be improved' rather than 'what is wrong' encourages looking for solutions.
- Be in an appropriate setting - positive feedback is effective when highlighted in the presence of peers or patients. Constructive criticism should be given in private. An office or some neutral territory where you are undisturbed is ideal.
- Be democratic - surgeons should be given the chance to comment on the fairness of the feedback and to provide explanations.

The above advice is adapted from Vickery & Lake (2005). Those responsible for providing constructive feedback may benefit from undertaking courses designed to provide further training and experience in feedback and appraisal.



# 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.

#### **Examples of poor behaviours**

- Orders inappropriate or unnecessary investigations
- Fails to appreciate that surgical underperformance will directly impact on patient safety and health outcomes
- Fails to ensure that a clear post-operative plan is available
- Fails to respond promptly and appropriately to post-operative complications or concerns about potential complications

#### **Examples of good behaviours**

- Provides a consistently high standard of peri-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 appropriate use of fluids, electrolytes and blood products including their adjustment according to patient progress

**Assessment**

Poor

Marginal

Good

Excellent

Unable to Rate

### Monitoring and evaluating care

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

#### **Examples of poor behaviours**

- Fails to regularly attend peer review meetings or audit own results
- Rationalises blame to others for poor outcomes when clearly at fault
- Makes no comparisons of their work to others' results or agreed standards
- Does not evaluate and appraise changes in practice

#### **Examples of good behaviours**

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

**Assessment**

Poor

Marginal

Good

Excellent

Unable to Rate



# Managing safety and risk

Ensuring patient safety by understanding and appropriately managing clinical risk.

### Examples of poor behaviours

- Undertakes hasty clinical assessment, missing critical issues e.g. anticoagulant use
- Proceeds with surgery knowing that equipment or facilities are inadequate or not ready for safe use
- Fails to participate in hospital or operating room surgical safety checklist processes
- Ignores incident reporting systems

### Examples of good behaviours

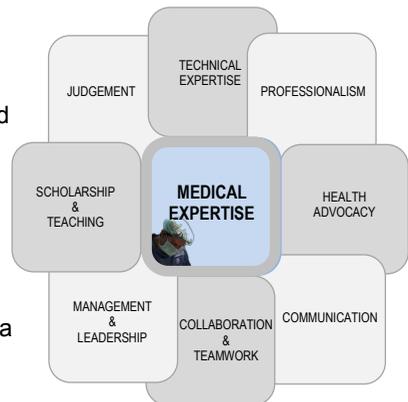
- Always undertakes an appropriate preoperative assessment of patients
- Demonstrates awareness of unlikely but serious potential problems and prepares accordingly
- Uses appropriate aseptic techniques, including regular hand washing, to minimise the risk of infection
- Promotes participation in and adherence to surgical safety checklists and other risk reduction strategies

**Assessment**    Poor     Marginal     Good     Excellent     Unable to Rate

**Comment regarding Medical Expertise** (Required if any Poor or Marginal ratings have been given, otherwise optional)

## Resources and support

- 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, 2006a)
- Cumulative Sum Techniques for Surgeons: a brief review (Yap et al., 2007)



# Judgement & Decision-making

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

## Considering options

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

### **Examples of poor behaviours**

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

### **Examples of good behaviours**

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

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---

## Planning ahead

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

### **Examples of poor behaviours**

- Does not consider or undertake pre-operative preparation
- Does not involve or consider operating room or other relevant clinical staff in operative planning
- Fails to consider patient-specific comorbidities in post-operative case planning
- Neglects to inform operating room staff of the need for specific instruments, equipment or implants

### **Examples of 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
- Is decisive and makes decisions in a timely manner
- Identifies the level of post-operative care that will be required and ensures that facilities are appropriate

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---



## Implementing and reviewing decisions

Undertaking the chosen course of action and continually reviewing its suitability in light of changes in the patient's condition.

### Examples of poor behaviours

- Frequently fails to implement decisions
- Makes the same error repeatedly
- Inflexible when evidence is mounting that an alternative course of action is advisable
- Makes decisions in haste and does not review them, even when time permits

### Examples of good behaviours

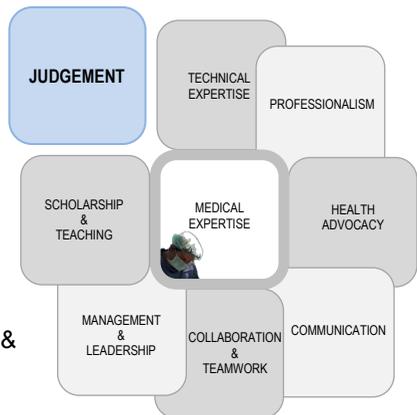
- Implements decisions within an appropriate timeframe
- Reconsiders plans in the light of changes in patient condition or when problems occur
- Calls for assistance if required
- Routinely follows up investigation results and surgical specimen pathology

**Assessment**      Poor     Marginal     Good     Excellent     Unable to Rate

**Comment regarding Judgement & Decision-making** (Required if any Poor or Marginal ratings have been given, otherwise optional)

## Resources and support

- RACS and other courses:
  - Care of the Critically Ill Surgical Patient (CCrISP)
  - Early Management of Severe Trauma (EMST)
  - Management of Surgical Emergencies (MOSES)
  - Definitive Surgical Trauma Care (DSTC)
- Safety at the sharp end (Flin, O'Connor & Crichton, 2009)



# Technical Expertise

Safely and effectively performing appropriate surgical procedures.

## Recognising conditions for which surgery may be necessary

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

### **Examples of poor behaviours**

- Focuses on the surgical procedure without adequate consideration of non-surgical options
- Inappropriately chooses most aggressive procedure without regard for the condition of the patient
- Performs surgery prematurely or inappropriately given the patient's diagnosis or current condition
- Will not discuss justification for any decisions

### **Examples of good behaviours**

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

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---

## 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.

### **Examples of poor behaviours**

- Rushes through procedures with disregard for the need for care and attention to detail
- Introduces new technology or procedures without adequate prior assessment and consultation
- Denies the impact of ageing or physical impairment on manual dexterity or technical skills
- Carelessly handles surgical instruments or equipment

### **Examples of good behaviours**

- Goes through the appropriate processes when learning a new technique e.g. visiting a surgical expert or mentoring
- Participates in simulation exercises or 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

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---



## Defining scope of practice

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

### Examples of poor behaviours

- Continues when the help of others would clearly be of benefit
- Fails to refer appropriately or in a timely manner
- Lacks insight into own surgical capabilities, undertaking procedures better performed elsewhere
- Takes on cases beyond scope of training when other alternatives are available

### Examples of 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
- Calls on advice and help with difficult problems outside normal scope of practice
- Modifies scope of practice in accordance with current experience

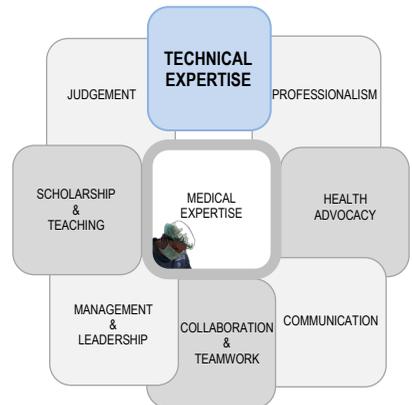
**Assessment**    Poor     Marginal     Good     Excellent     Unable to Rate

### Comment regarding Technical Expertise

(Required if any Poor or Marginal ratings have been given, otherwise optional)

## Resources and support

- RACS Course:
  - Advanced Minimal Access Surgery – An advanced skills workshop for surgeons interested in minimal access tissue approximation techniques
- General Guidelines for Assessing, Approving & Introducing New Procedures into a Hospital or Health Service (RACS/ASERNIP-S, 2008b)
- Craft group 'How to do it' courses
- Regular attendance at specialty meetings / RACS Annual Scientific Congress



# Professionalism

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

## Having awareness and insight

Reflecting upon one's surgical practice and having insight into its implications for patients, colleagues, trainees and the community.

### **Examples of poor behaviours**

- Is difficult to contact post-operatively and admonishes staff for continued attempts to make contact
- Blames registrars or others for poor outcomes
- Books inappropriately long lists or is misleading with theatre staff/anaesthetists regarding the length of operations
- Berates or humiliates subordinates

### **Examples of good behaviours**

- Adopts a courteous approach to other staff and patients
- Responds positively to questioning, suggestion and objective criticism
- Admits to errors
- Acknowledges poor outcomes and takes opportunities to reflect and improve

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---

## Observing ethics and probity

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

### **Examples of poor behaviours**

- Makes questionable claims for medical benefits, insurance, third party or workers compensation payments
- Exhibits bullying, harassing or sexist attitudes towards trainees, staff or patients
- Breaches confidentiality by discussing patient details in public areas
- Seeks to shift blame onto a patient for one's own professional transgressions

### **Examples of good behaviours**

- Provides an ethical role-model for other staff
- Ensures all research projects are reviewed and approved by a research and ethics committees
- Seeks informed consent of the patient before carrying out sensitive or invasive examinations or treatment
- Maintains appropriate personal and sexual boundaries with patients at all times

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---



## Maintaining health and well-being

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

### Examples of poor behaviours

- Uses alcohol indiscriminately 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

### Examples of good behaviours

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

**Assessment**      Poor     Marginal     Good     Excellent     Unable to Rate

### Comment regarding Professionalism

(Required if any Poor or Marginal ratings have been given, otherwise optional)

## Resources and support

- Professionalism of surgeons: A collective responsibility (Davies, 2011)
- Surgical professionalism in the 21st century (McCulloch, 2006)
- Professionalism in Medicine (CMA, 2001)
- Code of Conduct (RACS, 2011)
- Informed Financial Consent (RACS, 2006b)
- Preparation for Practice: A Guide for Younger Fellows (RACS, 2011)
- Understanding Doctors Harnessing Professionalism (Levenson et al, 2008)



# Health Advocacy

Identifying and 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.

### **Examples of poor behaviours**

- Delegates the process of informed consent to inexperienced juniors
- Lacks 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

### **Examples of 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 a distressed patient to actively listen to their concerns

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---

## 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.

### **Examples of 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 assessment in the context of a patient's physical or cognitive disability
- Fails to keep track of issues affecting patients waiting for surgery

### **Examples of good behaviours**

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

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---



## 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.

### Examples of poor behaviours

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

### Examples of good behaviours

- Strives to improve access to health care services
- Recognises the wider health needs of the community in an under-resourced system
- Contributes to community education and development
- Addresses issues raised by people's cultural and linguistic backgrounds

**Assessment**      Poor     Marginal     Good     Excellent     Unable to Rate

### Comment regarding Health Advocacy

(Required if any Poor or Marginal ratings have been given, otherwise optional)

## Resources and support

- The Australian Medical Association has a range of publications relating to public health issues (AMA – Public Health, 2008)
- The Australian Resource Centre for Healthcare Innovation (ARCHI) has a number of educational resources on cultural competency (ARCHI, 2007)
- The Health Issues Centre is an organisation that aims to improve the health outcomes of Australians, and has a range of publications relating to advocacy (Health Issues Centre)
- RACS Indigenous Health Position Paper (2009b)



# Communication

Communicating effectively with patients, families, carers, colleagues and others involved in health services in order to facilitate the provision of high quality health care.

## Gathering and understanding information

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

### **Examples of poor behaviours**

- Fails to acquire and review information relevant to the consultation or procedure
- Does not consider results of investigations until during a consultation or procedure
- Does not discuss potential problems
- Frequently asks for information to be read from patient notes during procedure

### **Examples of 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 for regular updates during surgery
- Ensures patient condition is monitored throughout the procedure and that changes and challenges are responded to appropriately

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---

## Discussing and communicating options

Discussing options with patients and communicating decisions clearly and effectively.

### **Examples of poor behaviours**

- Fails to involve or inform patient or team of surgical plan and expectations
- Is aggressive or unresponsive if the plan is questioned
- Fails to inform colleagues and staff of relevant issues and plans relating to on-going patient care when personally not available
- Appears to make decisions on the run and then responds to difficulties with irritation, aggression or inconsistency

### **Examples of good behaviours**

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

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---



## Communicating effectively

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

### Examples of poor behaviours

- Is discourteous to staff or patients
- Frequently talks in medical jargon to patients and fails to 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

### Examples of good behaviours

- Follows up test results and communicates them appropriately with the patient
- Encourages the surgical team to be involved and to ask questions and makes them feel their input is valued
- Demonstrates empathy and compassion when breaking bad news
- Shows awareness and sensitivity to patients from different cultural backgrounds and uses interpreters appropriately

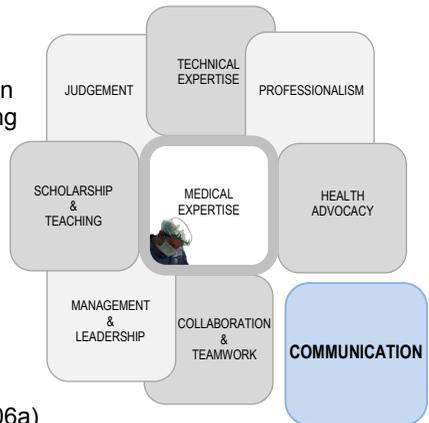
**Assessment**    Poor     Marginal     Good     Excellent     Unable to Rate

### Comment regarding Communication

(Required if any Poor or Marginal ratings have been given, otherwise optional)

## Resources and support

- RACS Courses: Communication Skills for Cancer Clinicians; Process Communication Model; Polishing Presentation Skills; Making Meetings More Effective
- Calgary-Cambridge Guide to the Medical Interview – Communication Process (Kurtz, 2003)
- The SEGUE Framework for Teaching & Assessing Communication Skills (Makoul, 2001b)
- Surgical Safety Checklist ANZ Edition (RACS 2009a)
- NOTSS System Handbook (Flin et al., 2006a)



# Collaboration & Teamwork

Ability to work cooperatively with peers, trainees and other health professionals to develop a shared picture of the clinical situation and facilitate appropriate task delegation, to ensure the delivery of safe, effective and efficient surgery.

## Documenting and exchanging information

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

### **Examples of poor behaviours**

- Does not listen to the views and opinions of team members or practice staff
- Demands assistance from team and staff members but does not make it clear what is required
- Actions demonstrate disregard for clinical opinions of others
- Fails to ensure provision of timely information to patients' referring doctor or general practitioner

### **Examples of 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
- Makes the effort to communicate directly and convey critical information to others involved in management (e.g. GP or other specialist)
- Records contemporaneous and legible notes regarding patient care

**Assessment**

Poor

Marginal

Good

Excellent

Unable to Rate

## 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.

### **Examples of poor behaviours**

- Fails to do regular ward rounds or initiate collective discussion and review of patient progress
- Fails to keep anaesthetist informed about risks or progress of the procedure
- Does not welcome discussion or review of the post-operative management
- Does not take into account suggestions or opinions of hospital or practice staff

### **Examples of 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
- Encourages input from members of the team including junior medical staff and nurses
- Debriefs relevant team members, discussing what went well and problems that occurred

**Assessment**

Poor

Marginal

Good

Excellent

Unable to Rate



## Playing an active role in clinical teams

Working together with other team members to gain an understanding of the clinical situation and to ensure all management issues are addressed, both for the individual patient and for the service provided.

### Examples of poor behaviours

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

### Examples of 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 reliably on time to facilitate commencement of the operation

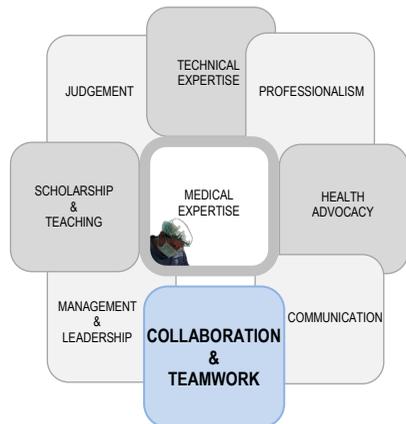
**Assessment**    Poor     Marginal     Good     Excellent     Unable to Rate

### Comment regarding Collaboration & Teamwork

(Required if any Poor or Marginal ratings have been given, otherwise optional)

## Resources and support

- RACS Courses:  
Surgeons and Administrators: Working Together to Bridge the Divide
- The Leadership and Management of Surgical Teams (Giddings & Williamson, 2007)
- Developing a Safety and Quality Framework for Australia (The Australian Commission on Safety and Quality in Health Care, 2011)
- NOTSS System Handbook (Flin et al., 2006a)



# Management & Leadership

Leading, providing direction, promoting high standards, matching resources to demand for services and showing consideration for all members of staff.

## Setting and maintaining standards

Ensuring quality and safety by adhering to accepted principles of surgery, complying with codes of professional conduct, and following clinical and operating room protocols.

### **Examples of poor behaviours**

- Fails to observe appropriate and established standards or protocols
- Is disrespectful to patients or staff
- Disregards the opinions and concerns of colleagues from other clinical disciplines
- Is disorganised, unreliable, frequently uncontactable or chronically late

### **Examples of 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 management issues

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---

## Leading that inspires others

Retaining control when under pressure by showing effective leadership and supporting team members.

### **Examples of poor behaviours**

- Becomes immobile and displays inability to make decisions under pressure
- Reluctant to seek immediate assistance when unexpected technical requires other expertise
- Blames others for errors and does not take personal responsibility
- Becomes irrational, loses temper repeatedly or inappropriately under pressure

### **Examples of 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

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---



## Supporting others

Providing cognitive and emotional help to team members, assessing their abilities and tailoring one's style of leadership accordingly.

### Examples of poor behaviours

- Does not provide recognition or feedback for tasks performed well
- Fails to recognise the needs of other team members and provide support
- Shows hostility or rivalry towards peers and is openly critical of colleagues
- Repeatedly displays a negative attitude towards junior medical staff, nurses and other health care professionals

### Examples of good behaviours

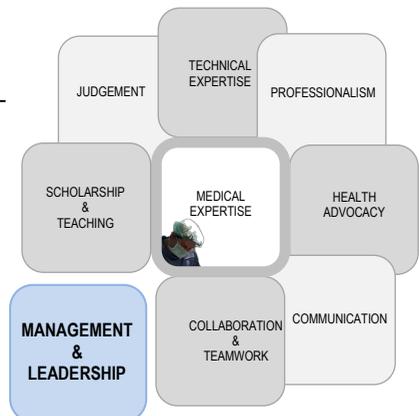
- Organises operation lists to ensure that there is time for trainees and junior staff to have supervised hands on experience
- Ensures delegation of tasks is appropriate
- Encourages and facilitates briefing and debriefing procedures involving the entire team
- Provides constructive criticism to team members

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---

**Comment regarding Management & Leadership** (Required if any Poor or Marginal ratings have been given, otherwise optional)

## Resources and support

- RACS Courses: Advanced Diploma of Management; Providing Strategic Direction; Sustaining Your Business; Leadership in a Climate of Change; Practice Makes Perfect - Principles for Practice Management
- Support for surgeons is often best provided by colleagues in similar positions in equivalent sized hospitals or practices e.g. in discussion or journal clubs
- The Leadership and Management of Surgical Teams (Giddings & Williamson, 2007)
- NHS Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement, 2007)



# Scholarship & Teaching

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

## Showing commitment to lifelong learning

Engaging in lifelong reflective learning, assimilating knowledge and imparting it to others.

### **Examples of poor behaviours**

- Fails to adjust practice according to current evidence
- Demonstrates critical errors in understanding of evidence available from current literature
- Shows little interest in participating in journal clubs, grand rounds and/ or clinico-pathological meetings
- Demonstrates apathy towards training and development of junior staff

### **Examples of good behaviours**

- Participates regularly in conferences, courses and other CPD activities
- Willingly reconsiders current practice and embraces change when based on sound evidence
- Engages with staff and encourages their learning, development and career planning
- Demonstrates awareness of the recent literature and considers implications for clinical and office practice

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---

## Teaching, supervision and assessment

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

### **Examples of poor behaviours**

- Demonstrates arrogance, rudeness or disinterest in the training of junior staff or students
- Fails to delegate appropriately or support junior staff
- Avoids being involved in identifying and remediating poor performance in a trainee
- Places unreasonable expectations on or is unduly critical of junior staff

### **Examples of 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
- Takes education and training seriously, allocating sufficient time for teaching and tutorials

<b>Assessment</b>	Poor <input type="checkbox"/>	Marginal <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>	Unable to Rate <input type="checkbox"/>
-------------------	-------------------------------	-----------------------------------	-------------------------------	------------------------------------	---



## Improving surgical practice

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

### Examples of poor behaviours

- Is dismissive or uncooperative with approved surgical research projects
- Promotes a 'it works for me, therefore it is right' approach despite a lack of supporting evidence
- Ignores research and ethics approval requirements when conducting clinical trials or evaluating new surgical techniques
- Fails to obtain informed consent from the patient or provide appropriate follow-up when a procedure undertaken is innovative or new

### Examples of good behaviours

- Strives to improve surgical practice through research, innovation and audit of outcomes
- Actively promotes best practice and evidence-based surgery principles
- Is prepared to alter clinical practice when audit and peer review suggests performance is suboptimal or there are opportunities to improve
- Always looks for better solutions to improve quality of care

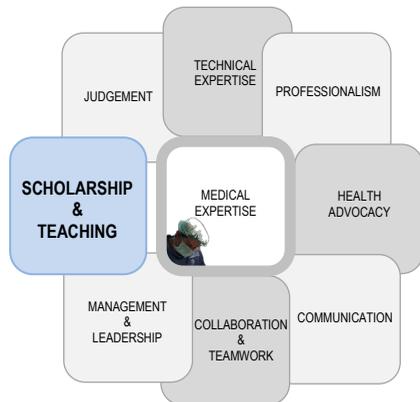
**Assessment**    Poor     Marginal     Good     Excellent     Unable to Rate

### Comment regarding Scholarship & Teaching

(Required if any Poor or Marginal ratings have been given, otherwise optional)

## Resources and support

- RACS Courses
  - Surgical Teachers Course;
  - Supervisors Course (SATSET);
  - Critical Literature Evaluation and Research (CLEAR);
  - Keeping Trainees on Track
  - Selection Interviewer Training
- RACS CPD Online service
- 'Teaching on the Run' programs
- University Medical Education and Research courses



# Assessment Tools

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

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

With practising surgeons, the aim is to assess 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 recording details of their participation in CPD (either online or through the annual 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 trainee concerned and reviewing all the evidence. It is also important to be aware of any bias, 'spin', interpretations or assumptions that may have been made.

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



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

### ***Surgical audit and peer review***

The College requires that all surgeons who undertake operative procedures 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 2008a)

### ***Performance review***

There is potential benefit from an annual performance review provided that it follows an agreed format and content across all competencies, involves the Director of Surgery and is not used to denigrate surgeons. The process should focus on continuous improvement of surgical performance. Performance review implies agreeing, prior to the period being reviewed, upon the measures of performance. Therefore each surgeon must be engaged and agree to the process prior to the review period.

### ***Review of adverse events, complaints and incidents***

Surgeons should take the opportunity to participate in the reporting and review of complaints, adverse events and incidents.

Adverse events (unintentional harm arising from an episode of healthcare) are often multifactorial in cause. Reviews of adverse events are generally conducted in order to identify the factors involved in the generation of the event and to provide opportunities to learn from it and improve the system of healthcare. The surgeon's own performance is often one of the factors to be considered in such a review.

Patients have a right to complain and also for their complaint to be considered seriously and responded to. Complaints provide another opportunity for surgeons to reflect on their performance and whether any aspect of their practice can be improved.



## ***Review of adverse events, complaints and incidents cont'd.***

Incidents that are reported to the governance units of hospitals and healthcare organisations often include adverse events and complaints, but may also relate to a surgeon's behaviour or perceived behaviour. Health care professionals are encouraged to report incidents, in the expectation that the response to incidents will result in improved delivery of service. Reported incidents should be considered carefully, investigated without prejudice and the issues raised addressed, so as to offer opportunities to improve the performance of either individuals or the whole system of healthcare.

### ***Case review***

Case review is a form of audit that is typically undertaken when a surgeon's performance is questioned, or under review. Approximately 20 individual cases are reviewed either within a specific area of performance or across a range of surgical competencies. This method is limited by what is documented and depends on agreeing the appropriate management plan beforehand from the clinical information and investigations available. A number of cases can be reviewed to determine aggregates (i.e. audit) but individual cases can also be reviewed to look at specific processes and whether these processes are being followed (including documentation).

### ***Multi-source feedback***

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

It is vitally important that the results of performance assessments are fed back to surgeons in a respectful, constructive and sensitive manner and provide a basis for continuous improvement and professional development.

### ***Specific surgical competencies***

The patterns of behaviour and their markers outlined in this Guide provide a system of assessment across the nine surgical competencies. Many of the markers describing good behaviours are intended to be 'aspirational'. The examples of poor behaviours may indicate the need for remediation or support and provide an opportunity for constructive feedback.



# 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: [cpd.college@surgeons.org](mailto:cpd.college@surgeons.org)

Website: [www.racgp.org.au/publications/tools#9](http://www.racgp.org.au/publications/tools#9)

## Consult your General Practitioner

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

## Support networks and surgical friends

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

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



## Strengthening your skills

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

## Peer support networks

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

### **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](mailto: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](http://www.surgeons.org).*

### **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.usanz.org.au](http://www.usanz.org.au)



# Need more help?

## RACS Executive Director of Surgical Affairs

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

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

Mr Allan Panting (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](mailto:college.act@surgeons.org)

### NSW Regional Committee

Telephone: + 61 2 9331 3933

Email: [college.nsw@surgeons.org](mailto:college.nsw@surgeons.org)

### NT Regional Committee

Telephone: + 61 8 8920 6029

Email: [college.nt@surgeons.org](mailto:college.nt@surgeons.org)

### SA Regional Committee

Telephone: + 61 8 8239 1000

Email: [college.sa@surgeons.org](mailto:college.sa@surgeons.org)

### QLD Regional Committee

Telephone: + 61 7 3835 8600

Email: [college.qld@surgeons.org](mailto:college.qld@surgeons.org)

### TAS Regional Committee

Telephone: + 61 3 6223 8848

Email: [college.tas@surgeons.org](mailto:college.tas@surgeons.org)

### VIC Regional Office

Telephone: + 61 3 9249 1255

Email: [college.vic@surgeons.org](mailto:college.vic@surgeons.org)

### WA Regional Committee

Telephone: +61 8 6488 8699

Email: [college.wa@surgeons.org](mailto:college.wa@surgeons.org)

### NZ National Board

Telephone: + 64 4 385 8247

Email: [college.nz@surgeons.org](mailto:college.nz@surgeons.org)



## Doctors' Health Advisory Services

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

- ACT:** Colleague of First Contact (24hr)  
Helpline: +61 407 265 414
- NSW:** Doctors' Health Advisory Service (24hr)  
Helpline: + 61 2 9437 6552  
Website: www.dhas.org.au
- NT:** Doctors' Health Advisory Service (24hr)  
Helpline: + 61 2 9437 6552
- SA:** Doctors' Health Advisory Service (24hr)  
Helpline: +61 8 8273 4111
- QLD:** Doctors' Health Advisory Service (24hr)  
Helpline: +61 7 3833 4352
- TAS:** AMA Peer Support Service (8am – 11pm)  
Helpline: +61 1300 853 338
- VIC:** Victorian Doctors Health Program (24hr)  
Telephone: +61 3 9495 6011
- WA:** Colleague of First Contact (24hr)  
Helpline: +61 8 9321 3098
- NZ:** Doctors' Health Advisory Service (24hr)  
Helpline: +64 4 471 2654

## Australian Medical Association (AMA) Telephone Assistance

Victoria Peer Support Service - +61 1300 853 338

## Rural Support

**Australia:** The Bush Crisis Line and Support Services: +61 1800 805 391 (24hr)  
A confidential telephone support and debriefing service.

## Lifeline:

**Australia:** Telephone: +61 13 11 14



## Other Services

### Alcoholics Anonymous

**Australia:**

Telephone: +61 2 9599 8866

Website: [www.aa.org.au](http://www.aa.org.au)

**New Zealand:**

Telephone: +64 800 229 675

Website: [www.alcoholics-anonymous.org.nz](http://www.alcoholics-anonymous.org.nz)

### Alcohol and Drug Information Service

**Australia:**

Telephone: 1800 422 599 (24hrs)

### Alcohol Drug Helpline

**New Zealand:**

Telephone: +64 800 787 797

Website: [www.adanz.org.nz](http://www.adanz.org.nz)

### Narcotics Anonymous

**Australia:**

Telephone: +61 1300 652 820

Website: [www.naoz.org.au](http://www.naoz.org.au)

**New Zealand:**

Telephone: +64 800 628 632

Website: [www.nzna.org](http://www.nzna.org)

### Australian Hearing

Telephone: + 61 2 9412 6800

Website: [www.hearing.com.au](http://www.hearing.com.au)

### Hearing Association New Zealand

Telephone: + 64 800 233 445

Website: [www.hearing.org.nz](http://www.hearing.org.nz)

### Vision Australia

Telephone: +61 1300 84 74 66

Website: [www.visionaustralia.org.au](http://www.visionaustralia.org.au)

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



# Appendix 1

## Performance Assessment Steering Committee

The Performance Assessment Steering Committee reported to the Professional Standards Committee under the governance of the Professional Development and Standards Board (PDSB). The PDSB reports to the College Council.

The Performance Assessment Steering Committee comprised the following members:

Professor David Watters, Chair and General Surgeon, VIC\*  
Mr John Batten, Orthopaedic surgeon, TAS  
Mr John Graham, Vascular surgeon, NSW\*  
Associate Professor Peter Woodruff, Vascular surgeon, QLD\*  
Mr Philip Truskett, General surgeon, NSW  
Mr Simon Williams, Orthopaedic surgeon, VIC\*  
Mr Patrick Alley, General surgeon, New Zealand  
Dr Patrick Lockie, Ophthalmologist, VIC and MIIAA representative  
Mr Allan Panting, RACS Executive Director of Surgical Affairs – New Zealand  
Dr John Quinn, RACS Executive Director of Surgical Affairs – Australia\*  
Professor Bruce Barraclough, RACS Dean of Education  
Dr Ian Graham, RACS Project Manager (SED Health Consulting)\*  
Dr David Hillis, RACS Chief Executive Officer  
Dr Pam Montgomery - RACS Director, Fellowship and Standards\*  
Ms Kathleen Hickey, RACS Director, Education Development and Assessment  
Dr Wendy Crebbin, RACS Manager, Education Development and Research\*

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

The first edition of the Surgical Competence and Performance Guide was developed by Dr Ian Dickinson (chair) and former members of the Surgical Competence and Performance Working Party (SCPWP). Members were Professor Guy Maddern, Dr Mark Edwards, Professor Andre van Rij, Associate Prof Jenepher Martin, Professor Michael Grigg, Mr Andrew Roberts, Mr Gary Speck, Dr Chris Cain, Associate Professor Julian Rait, Mr John Simpson and Professor John Collins and those asterisked above. The Performance Assessment Steering Committee and PDSB gratefully acknowledge the work of Dr Dickinson and former members of the SCPWP.



# Appendix 2

## References

ACSQHC (2011) Developing a Safety and Quality Framework for Australia  
[www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/1F9C50F1CF5C3851CA257753001FAC79/\\$File/Developing%20a%20Safety%20and%20Quality%20Framework%20for%20Australia](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/1F9C50F1CF5C3851CA257753001FAC79/$File/Developing%20a%20Safety%20and%20Quality%20Framework%20for%20Australia).

PDFAMA – Public Health (2008) Position Statements on Public Health. Australian Medical Association [www.ama.com.au/policy](http://www.ama.com.au/policy)

Antonioni D, Woeh D (2001) Improving the Quality of Multisource Rater Performance, Chapter 8, *The Handbook of Multisource Feedback: the comprehensive resource for designing and implementing MSF processes*, Bracken D, Timmreck C, Church A (editors), The Jossey-Boss business and management series pp 114 – 129

ARCHI (2007) Australian Resource Centre for Healthcare Innovation [www.archi.net.au](http://www.archi.net.au)

Banderiera G, Sherbino J, Frank J (2006) *The CanMEDS Assessment Tools Handbook – An Introductory Guide to Assessment methods for the CanMEDS Competencies*, 1<sup>st</sup> Edition. The Royal College of Physicians and Surgeons of Canada.

CMA (2001) Professionalism in medicine (Canadian Medical Association series of health care discussion papers).  
[www.cma.ca/multimedia/staticContent/HTML/N0/I2/discussion\\_papers/professionalism/pdf/professionalism.pdf](http://www.cma.ca/multimedia/staticContent/HTML/N0/I2/discussion_papers/professionalism/pdf/professionalism.pdf)

Collins J, Gough I, Civil, I, Stitz R (2007) A New Surgical Education and Training Programme. *ANZ Journal of Surgery* 2007; 77(7):497-501

Davies G (2011) Professionalism of surgeons: A collective responsibility. *Aust NZ J Surg* 2011;81; 219 - 226

Flin R, Yule S, Paterson-Brown S, Rowley D, Maran N (2006a) *The Non-Technical Skills for Surgeons (NOTSS) System Handbook v1.2*, University of Aberdeen & Royal College of Surgeons of Edinburgh.

Flin R, Yule S, McKenzie L, Paterson-Brown S, Maran N (2006b) Attitudes to teamwork and safety in the operating theatre. *The Surgeon*, 2006; 4: 145-151.



## References cont'd.

Flin R, O'Connor P, Crichton M (2009) Safety at the sharp end: a guide to non-technical skills, Ashgate Publishing Limited, England.

Gawande A (2007) Better: A surgeon's notes on performance. Metropolitan Books, New York.

Gawande A (2010) Letting Go: What Should Medicine Do When it Can't Save your Life? The New Yorker [www.newyorker.com](http://www.newyorker.com)

Giddings A, Williamson C (2007) The Leadership and Management of Surgical Teams, The Royal College of Surgeons of England.  
[www.rcseng.ac.uk/publications/docs/leadership\\_management.html/attachment\\_download/pdf](http://www.rcseng.ac.uk/publications/docs/leadership_management.html/attachment_download/pdf)

Health Issues Centre [www.healthissuescentre.org.au](http://www.healthissuescentre.org.au)

Kurtz S (2003) Marrying content and process in clinical method teaching: enhancing the Calgary Cambridge Guides. Acad Med 2003; 78(8):802-9.

Calgary-Cambridge Observation Guide 1 -  
[www.acgme.org/outcome/downloads/landC\\_2.pdf](http://www.acgme.org/outcome/downloads/landC_2.pdf)

Levenson R, Dewar S, Shepherd S (2008) Understand Doctors Harnessing Professionalism, 1<sup>st</sup> Edition. The Royal College of Physicians.  
[http://www.kingsfund.org.uk/publications/understanding\\_docs.html](http://www.kingsfund.org.uk/publications/understanding_docs.html)

Makoul G (2001a) Essential elements of communication in medical encounters: the Kalamazoo consensus statement. Acad Med 2001; 76(4):390-3.

Makoul G (2001b) The SEGUE framework for teaching and assessing communication skills. Patient Educ Couns 2001; 45(1):23-34.

Segue Framework - [www.acgme.org/outcome/downloads/landC\\_11.pdf](http://www.acgme.org/outcome/downloads/landC_11.pdf)

McCulloch P (2006) Surgical professionalism in the 21st century. The Lancet. London: Jan 14-20, Vol. 367, Issue 9505; pg. 177-181.

NHS Institute for Innovation and Improvement (2007) Medical leadership competency framework.  
[www.institute.nhs.uk/building\\_capability/enhancing\\_engagement/mlcf.html](http://www.institute.nhs.uk/building_capability/enhancing_engagement/mlcf.html)



## References cont'd.

RACS (2006a) Royal Australasian College of Surgeons - Guidelines for Managing an Outlier through Structured Audit Processes. [www.surgeons.org](http://www.surgeons.org)

RACS (2006b) Royal Australasian College of Surgeons - Informed Financial Consent. [www.surgeons.org](http://www.surgeons.org)

RACS (2008a) Royal Australasian College of Surgeons - Surgical Audit and Peer Review. 3<sup>rd</sup> ed. [www.surgeons.org](http://www.surgeons.org)

RACS/ASERNIP-S (2008b) Royal Australasian College of Surgeons General Guidelines for Assessing, Approving & Introducing New Procedures into a Hospital or Health Service. 2<sup>nd</sup> ed. [www.surgeons.org](http://www.surgeons.org)

RACS (2009a) Surgical Safety Checklist ANZ Edition [www.surgeons.org](http://www.surgeons.org)

RACS (2009b) Indigenous Health Position Paper [www.surgeons.org](http://www.surgeons.org)

RACS (2011) Royal Australasian College of Surgeons - Code of Conduct. 2<sup>nd</sup> ed. [www.surgeons.org](http://www.surgeons.org)

RACS (2011) Royal Australasian College of Surgeons - Preparation for Practice: A Guide for Younger Fellows. 3<sup>rd</sup> ed. [www.surgeons.org](http://www.surgeons.org)

Rethans J-J, Norcini J, Baron-Maldonado M, Blackmore D, Jolly B, LaDuca T, Lew S, Page G, Southgate L. (2002) The relationship between competence and performance: implications for assessing practice performance. *Med Educ* 2002; 36:901-909.

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.

Vickery A, Lake F (2005) Teaching on the run tips 10: giving feedback. *MJA*, Volume 183, Number 5, 5 September 2005, as quoted in the Royal Australasian College of Physicians Feedback summary, Education Deanery, RACP, 2010.

Watters D, Green A, van Rij A (2006) Guidelines for surgical audit in Australia and New Zealand. *ANZ J. Surg.* 76: 78-83.

Yap C, Colson M, Watters D (2007) Cumulative Sum Techniques for Surgeons: A Brief Review. *ANZ J. Surg.* 77: 583-6.

Yule S, Flin R, Paterson-Brown S, Maran N. (2006) Non-technical skills for surgeons: A review of the literature. *Surgery* 2006; 139: 140-149.

