

POSITION STATEMENT ON EMERGENCY SURGERY

This position statement has been developed by the Royal Australasian College of Surgeons in response to concerns from Fellows of this College and other Colleges about the increasing difficulties experienced providing adequate emergency and trauma care. These difficulties cover resourcing and also adequate workforce to provide the required service. It is important that the College sets standards for surgery and is involved in policy development in relation to the provision of emergency surgical services to the communities of Australia and New Zealand.

Patients who present to hospitals with acute surgical conditions, including trauma are significant consumers of health resources in Australia and New Zealand. The community expects expert quality care when presenting at emergency departments and acute care facilities.

There has been a drive in healthcare towards the reduction of elective surgery waiting lists. This is seen as an attractive way to demonstrate success to the community. However, this fails to recognise that emergency surgical admissions comprise a large group of all surgical admissions in Australia and New Zealand. As a consequence, scarce resources are sometimes preferentially allocated away from emergency surgery.

Emergency surgical patients often have complex and challenging problems, which may include major traumatic injury, sepsis, shock and serious abdominal conditions. These patients can present at any time of the day or night regardless of the staffing levels within individual hospitals. They may present to hospitals where there are less than adequate facilities for dealing with their particular problem. Mostly, the quality of medical care is of a high standard, although the staff who are expected to assess, resuscitate and provide care for these patients are often inexperienced or junior. Delays occur not only in the initial assessment of patients but also in the time to definitive management.

Public hospitals are overstretched. The reduction of bed numbers in most public hospitals in the last two decades has resulted in many emergency surgery patients remaining in overcrowded emergency rooms, which are neither equipped nor staffed to provide the ongoing care that such patients require.

Emergency surgery is often considered an inconvenient impediment to the performance of elective surgery and is scheduled only when time and operating space permits. Operating theatre access has become increasingly difficult leading to emergency surgery being performed late at night. If on the other hand, emergency cases are scheduled during the day, theatre demand can become too great. Therefore a tension and conflict develops between the needs of elective and emergency surgery. As well, delays in provision of surgery compound bed shortages and can increase patient morbidity.

Senior surgical and nursing staff are frustrated by the stress of trying to provide adequate emergency surgical services. Some of these staff are opting out of working in emergency care situations or choose to leave public hospital practice altogether. These frustrations are being witnessed by junior staff who may prefer to take career paths that avoid the need to participate in emergency care, thus compounding the problem.

The inevitable outcome of inadequate resources, critical staff shortages and an inability to attract motivated individuals to careers in emergency surgery is a threat to the future standard of emergency surgical care, in both Australia and New Zealand.

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To redress this current critical situation the Royal Australasian College of Surgeons makes the following recommendations:

Facilities

Hospitals need to be provided with appropriate and adequate facilities for accepting emergency patients. At the highest level, this includes 24 hour services with all the required surgical specialties and anaesthesia on call and available, with adequate nursing support and with adequate ancillary support (such as intensive care, pathology and radiology).

Where possible it is recommended that dedicated emergency theatre space be provided in which to perform emergency surgery so that elective surgery does not impact on the performance of emergency surgery and vice versa.

Rostering systems should be established so that surgeons can be available to perform emergency surgery in a timely fashion.

Smaller district general hospitals and rural hospitals require facilities appropriately resourced to the level of service which is being provided.

Adequate resourcing of infrastructure, workforce and appropriate management is essential at all levels, commensurate with the service expected. Reference to the RACS "Model Resource Criteria for Trauma Services" provides a guide to standards for trauma services and its equivalence for all emergency care.

Funding

Increased resources and funding of appropriate emergency care specifically directed at obtaining appropriate improvements in outcome must be channelled by the funders of healthcare services into the hospital system.

Adequate resourcing of workforce, infrastructure and management must be instituted to care for the acutely ill and injured in the community.

All of the staff involved in the provision of emergency surgery must be appropriately supported, rewarded and recompensed.

Leadership

Leadership of the surgical and clinical teams must be given credibility within the organisation, and must be given the opportunity to improve the provision of these services in their particular location/area/region.

There must be a coordinated system in terms of providing for the seriously ill and injured patients. There must also be a coordinated system for those who have less serious clinical conditions and who similarly need care in an appropriate and timely fashion.

The provision of major emergency (and/or trauma) centres in the large cities is important, but also the maintenance of standards of care in all hospitals providing emergency services must be of prime importance. There must not be under-resourcing and deskilling in facilities providing acute care surgery.

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Surgical appointments

Surgeons need to be specifically trained in the provision of acute surgical care. They must continue to perform emergency surgery work and their continued hospital credentialing and employment must include provision of emergency care.

The Royal Australasian College of Surgeons recognises the provision of emergency surgery is a core competency in surgery in all surgical specialities. Whilst surgeons may have sub-specialty or specific elective surgical skills, the provision of acute surgical care is an ongoing need of the community.

Hospitals which treat much of the emergency and trauma care will need a minimum number of General and Orthopaedic surgeons available. There also needs to be availability of surgeons in other specialties (Neurosurgery, Otolaryngology, Vascular surgery, Plastic surgery, Paediatric surgery, Cardiothoracic surgery, Urology and Ophthalmology) and many of these surgeons currently may not be appointed in such a way that a 24 hour roster can be covered. There may need to be local arrangements whereby surgeons from a number of different hospitals share care to provide appropriate services.

Radiology

Expert services providing radiological and other imaging need to be readily available. As well, image sharing facilities allowing hospital to hospital and hospital to other locations are required.

Pre-hospital care and triage

It is critical that ambulance (including air ambulance) services are available for pre-hospital care. A central co-ordinating facility is essential, and a short response time to attend to patients is required. Ambulances must be directed to the hospital most suited to the patient's particular needs. For complex multi system trauma patients, this will need to be the nearest level one trauma centre.

Inter-hospital transfer

There need to be protocols and resources in place for hospitals which are less well equipped to be able to transfer patients quickly. Retrieval teams from more central, well equipped hospitals need to be available at short notice so as not to cause delays or compromise patient care.

Organisation of clinical networks is highly desirable so as to co-ordinate care.

Model of care

There are various models for management of patients once accepted into the hospital, including surgical teams with appropriate handover arrangements. The clear priority is that appropriate handover is performed and that a patient is designated under the care of a particular surgeon. These arrangements will vary from hospital to hospital, but must be adequately supported by the institution.

To effect adequate care, appropriate rapid triage facilities must be available, operating theatres must be readily be available, and there must be a clear responsibility for leadership for making each patient's care efficient and appropriate.

Safe hours

Surgeons should work within the principles of working safe hours. Rosters need to be arranged such that a surgeon who works for a considerable proportion of the evening or night has the next

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day rostered off, and that this is appropriately remunerated. Surgeons cannot be expected to work safely during the day after being on duty overnight. Appropriate surgical facilities must be available for day time surgery and as much of the surgery as possible must be performed in protected day time and emergency surgery lists. These arrangements need to consider local situations and cater for Full Time Staff Surgeons and Visiting Surgeons.

Education

There are a number of different models of surgical education and specialisation which are able to support an appropriate emergency care surgical service.

Surgeons may specialise in emergency or trauma care or may choose to perform this surgery as part of their other specialty obligations. However, they must be supported appropriately (as described above). In the larger centres, surgeons who specialise only with emergency or trauma patients may be able to be employed just in that role, but in other centres (and in most hospitals) the more likely model is for surgeons to be part of a 'on call' roster.

The Royal Australasian College of Surgeons provides specific courses in the care of critically ill and trauma patients and surgeons must attend these as part of their surgical training. Surgeons are also encouraged to participate in relevant courses in acute care provision throughout their practising careers.

Adequate resourcing of continuing education in provision of emergency and trauma care needs to be part of the hospital - surgeon relationship such that standards can be maintained and improved.

Training, Teaching and Audit

In many hospitals there will be a requirement for training and teaching of junior staff and these roles must be supported by the institution. The junior staff must be given adequate time to learn new skills and senior clinical staff must be given time to teach as part of their hospital appointment.

Further Post Fellowship training will lead to appropriate career structures and leadership opportunities in emergency surgery and trauma.

Appropriate quality control, adequate data collection with research and audit facilities is required to assess outcomes and lead to quality feedback and improvements.

Outcomes

Inefficiencies in the system of retrieval, of triage, diagnostic investigation, access to the operating theatre, and appropriate post-operative care lead to significant morbidity. If further surgery is required, the delays in taking patients back to the operating theatre can mean much greater hospital time than should be required, and can jeopardise good clinical outcomes.

For patients who have serious acute surgical or traumatic conditions, the delays and inadequacies which are inherent in the current systems lead to significantly greater mortality and morbidity than is acceptable in modern first world communities. The provision of much more in the way of financial resources will improve outcomes. Effective leadership, teamwork and management lead to the best clinical outcomes

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Governments and funding bodies must address current system inadequacies to improve outcomes for patients presenting with acute surgical conditions.

The Royal Australasian College of Surgeons must be involved in the setting of standards of practice and care in the emergency environment, and wishes to offer expertise and guidance to meet local situations which vary widely.

References

Acute Care Surgery Curriculum, The American Association for the Surgery of Trauma (2007)
http://www.aast.org/acute_care_surgery.aspx?id=1250

A Trauma Plan for Queensland, Queensland Government and Royal Australasian College of Surgeons (2006)
http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/Regions/QLD/QLD_Trauma_plan_final_prac.pdf

Emergency General Surgery: The Future, A Consensus Statement, Association of Surgeons of Great Britain and Ireland (2007)
[http://www.asgbi.org.uk/consensus_statements/EGS_statement\(July07\).pdf](http://www.asgbi.org.uk/consensus_statements/EGS_statement(July07).pdf)

Guidelines for a Structured Approach to the Provision of Optimal Trauma Care, Royal Australasian College of Surgeons New Zealand Trauma Committee for the New Zealand Ministry of Health (Revised 2003)

Model Resource Criteria for Level I, II, III & IV Trauma Services in Australasia, The Royal Australasian College of Surgeons Trauma Verification Sub Committee (Revised 2006)
http://www.surgeons.org/Content/NavigationMenu/FellowshipandStandards/FellowshipServices/Trauma/Traumaverification/Trauma_Verification_Manual_Jan_2007.pdf

Position Paper on the Future of Trauma Surgery, The Eastern Association for the Surgery of Trauma (2005)
<http://www.east.org/tpg/futureposition.pdf>

Standards for Safe Working Hours and Conditions for Fellows, Surgical Trainees and International Medical Graduates Position Statement, The Royal Australasian College of Surgeons (2007)
http://www.surgeons.org/Content/ContentFolders/Policies/SafeHours_small_final_printout.pdf

Statement of Acute Care, American College of Surgeons (2007)
http://www.facs.org/fellows_info/statements/st-56.html

Surgical Audit and Peer Review Guidelines, The Royal Australasian College of Surgeons Surgical Audit Committee (2005)
http://www.surgeons.org/Content/NavigationMenu/FellowshipandStandards/ProfessionalStandards/CPDresourcesandtools/surgical_audit_peer_review.pdf

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