

Subject:	OUTREACH SURGERY IN REGIONAL, RURAL AND REMOTE AREAS OF AUSTRALIA AND NEW ZEALAND	Ref. No.	FES-FEL-033
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1. BACKGROUND

This position paper describes College guidelines for outreach surgery in regional, rural and remote Australia and New Zealand.

Outreach surgery aims to deliver specialist surgical services to regional, rural and remote patients who otherwise would have to travel great distances, often at significant personal cost or hardship to gain access to these services. The key to the provision of safe, appropriate, outreach surgery in Australia and New Zealand is a team approach with a considerate, co-operative, ethical and close liaison between the visiting surgeon and the resident surgeon and/or general practitioner and recognition of the facilities available and the skills of the resident doctors where the outreach surgery has been provided.

This position paper recognises that there is a shortage of specialist surgeons in regional, rural and remote Australia and New Zealand. It is also recognised, however, that whenever possible the best situation is to have the specialist surgeon resident in the community in which the service is provided.

The aims of this document are to present guidelines for:

- the provision of safe, efficient and appropriate outreach surgical care
- the ongoing education and professional support of rural surgeons, rural general practitioners and other health professionals involved in delivery of surgical services.

Only surgery appropriate to the facilities, personnel and geographic location should be considered. Credentialing and Privileging in accordance with the "Credentialing and Defining the Scope of Clinical Practice Handbook" of the Australian Commission on Safety and Quality in Health Care (in Australia) and its equivalent in New Zealand must also apply.

All Fellows of the College, including visiting surgeons, should abide by the College Code of Conduct.

2. INTRODUCTION

- 2.1. Because of the geography and population distribution of Australia and New Zealand, outreach surgery is currently a necessary part of the provision of some surgical services particularly to rural and remote areas.
- 2.2. Definition: Outreach surgery is any surgery performed by a surgeon in a town where that surgeon is not resident and may not be available in person for ongoing post-operative care, or follow up. Outreach services refer only to situations where the services being delivered are not normally available locally.
- 2.3. Surgeons should be appropriately trained in any field or specialty procedure they practice and be supported by appropriate facilities and staff to allow for safe performance of those procedures and post-operative care. In addition to training, credentialing to work in this facility must also be organised.
- 2.4. In many situations, outreach surgery will be provided on a day surgery basis. However, in situations where it is necessary for the patient to be an inpatient, appropriate arrangements for in-hospital care will need to be implemented.

3. BODY

Proper surgical practice requires that a surgeon be responsible for pre-operative diagnosis and appropriate investigation, the selection and performance of the operation, and the post-operative care of the patient. Part of this care may be delegated to associates under the

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surgeon's direction, and the patient should be agreeable to such delegation of care, but the surgeon remains responsible for the patient.

In addition to physical facilities, consideration need also be paid to anaesthetic services available in the outreach environment, either provided locally, or in a similar outreach provision of services.

Practice arrangements whereby a surgeon regularly performs operations in urban as well as distant centres, but does not arrange for the responsibilities of subsequent care and post-operative management in either setting, are unacceptable.

3.1. Overview

- 3.1.1. Primary clinical responsibility and legal liability for patient care; pre-operative, intra-operative and post-operative care rests with the operating surgeon.
- 3.1.2. The educational opportunity afforded by an outreach service should not be ignored. The visiting surgeon should allocate time for discussion and teaching with surgical colleagues and other relevant health professionals. The team concept must be developed and engaged.
- 3.1.3. Post-operative care requires a team approach involving the visiting surgeon, local doctors (including local surgeon, if involved), nursing staff and administration, involving proper communication and cooperation between all members of the team.
 - a. In towns with a resident surgeon, the visiting surgeon should communicate with and ideally, if indicated, involve the local surgeon.
 - b. In towns with no resident surgeon, the visiting surgeon must communicate with the doctor who is equipped to, and has agreed to supervise post-operative care.
- 3.1.4. The quality of care for patients in rural Australia and New Zealand should be equal to the care expected in an accredited metropolitan hospital.

3.2. Prerequisites

- 3.2.1. Credentialing

Outreach surgery requires that all medical practitioners, including the surgeon, are appropriately qualified for the procedures required of them, and that all medical practitioners, including the surgeon, have been credentialed overall by:

 - a. A Clinical Privileging/Credentialing Committee that advises the hospital administration of the areas of competence of that medical practitioner.
 - b. The hospital administration determining that the admitting privileges for that medical practitioner are in line with the designated role and facilities of the hospital, or day surgery facility.

3.3. Specific Requirements

- 3.3.1. Prior to any procedure being performed the visiting surgeon must:
 - a. Ensure that the on-site equipment and facilities are adequate for the procedure.

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- b. Ensure that the medical practitioner providing the anaesthetic service is suitably trained and privileged to provide anaesthetic service for that procedure and for the specific patient's anaesthetic risk category (ASA rating), according to the policy of the Australian and New Zealand College of Anaesthetists, *PS1 (2002)*.
- c. Ensure that there is adequate intra-operative assistance available from local medical practitioners or appropriate nursing staff.
- d. Arrange a doctor who has agreed to accept responsibility for providing appropriate post-operative care for that procedure and that patient.
- e. Ensure that the delegated doctor:
 - has access to the operating surgeon or the nominated cover at all times;
 - is aware of potential complications and able to recognise them;
 - is able to resuscitate patients in the event of life threatening complication; and
 - can provide post-operative management at a local level until the patient is discharged and appropriate monitoring until the patient is next seen by the visiting surgeon.
- f. Ensure that the hospital or post-operative unit involved has referral procedures and patient transfer policies for patients whose severity of illness reaches a level beyond the resources available at their hospital.
- g. Ensure, in consultation with the Director of Nursing, that nursing staff have expertise in pre/intra/post-operative care appropriate for the procedure, and that adequate numbers of nursing staff are available at all times.

3.4. Protocols

- 3.4.1. Prior to performing any procedure the visiting surgeon should provide the hospital with an appropriate admission form detailing the specific requirement and a written protocol containing at least details of the:
 - a. Personnel and equipment required for the procedure.
 - b. The pre and post-operative nursing care regime required (and check any existing nursing care clinical pathway plans).
 - c. The name and contact details of delegated doctor(s) and the care which is expected to be provided by the doctor who has agreed to provide that care.
 - d. Parameters defining the normal recovery of the patient from the procedure. Where a patient's progress deviates from these parameters, it is the responsibility of the person making the observation (often nursing staff) to ensure the visiting surgeon, who retains primary responsibility for the patient, is informed. This should preferably occur through the delegated doctor, or directly if the delegated doctor is not available and/or the patient's condition continues to deteriorate.

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- e. Routine post-operative communications expected by the surgeon, including designation of the person responsible for initiating the same. It is the responsibility of the local nurse or delegated doctor to document post-operative communications. It is the responsibility for the visiting surgeon who retains primary responsibility of the patient, to ensure that any requested routine communications do in fact occur.

3.5. Guidelines

3.5.1. Pre-operative

- a. All patients for elective procedures should receive appropriate pre-operative assessment by the surgeon prior to the appointed day of the procedure. Sometimes consultation may occur before surgery on the same day assuming there has been adequate prior communications between the patient, local doctor and the visiting specialist.
- b. The visiting surgeon should ensure that arrangements are made for the patient to have an appropriate, relevant anaesthetic assessment in advance of the procedure.
- c. The visiting surgeon is responsible for providing appropriate and sufficient information to the patient.
- d. The visiting surgeon is responsible for obtaining informed consent, which should include information and consent for the post-operative care to be provided by a delegated doctor other than the visiting surgeon.

3.5.2. Operative

- a. It is recommended that wherever possible the doctor delegated to provide post-operative care is present at the procedure, either as anaesthetist or as assistant. This may not always apply in the case of group practices or public hospitals. However ongoing and informed post-operative care must be arranged.
- b. In such cases where the delegated doctor has not been present at the procedure, the surgeon should communicate in person with that doctor before departing.
- c. Hand over procedures must take place consistent with the situation, and the procedure.
- d. The Surgical Safety Check list approach should be used.

3.5.3. Post-operative

- a. The visiting surgeon should not leave the local area until satisfied that the patient is in a stable condition and unlikely to need their immediate care. The visiting surgeon should be satisfied with the postoperative follow up arrangements.
- b. The visiting surgeon should be prepared to stay in the town overnight (or longer) after certain higher-risk procedures, or where a significant complication has occurred or where the surgeon considers a significant complication may occur.

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- c. The patient should have clear instructions as to the expected post-operative course for the operation and who to contact if they have concerns.

3.5.4. Continuing Education and Maintenance of Professional Standards

- a. As well as the provision of surgical services to patients, it is recommended the visiting surgeon allocate additional time for the ongoing education of surgical/medical colleagues and other relevant health care professionals (nurses, etc.) Appropriate surgical audit and documentation for continuing professional development needs to be maintained.
- b. A template checklist be developed for handover and follow-up.
- c. That IT be developed to allow remote access for results of investigations.

Approver: Chief Executive Officer
Authoriser: Professional Development and Standards Board