

An international comparative study of emergency surgery management

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Balancing Elective and Emergency Surgery

Empirical research conducted in Australia

- Fitzgerald JA, Lum ME, Dadich, A.
Scheduling unplanned surgery: a tool for improving dialogue about queue position.
Australian Health Review; May 2006; 30, 2: 219

Common issue in all health systems of developed countries – how common?

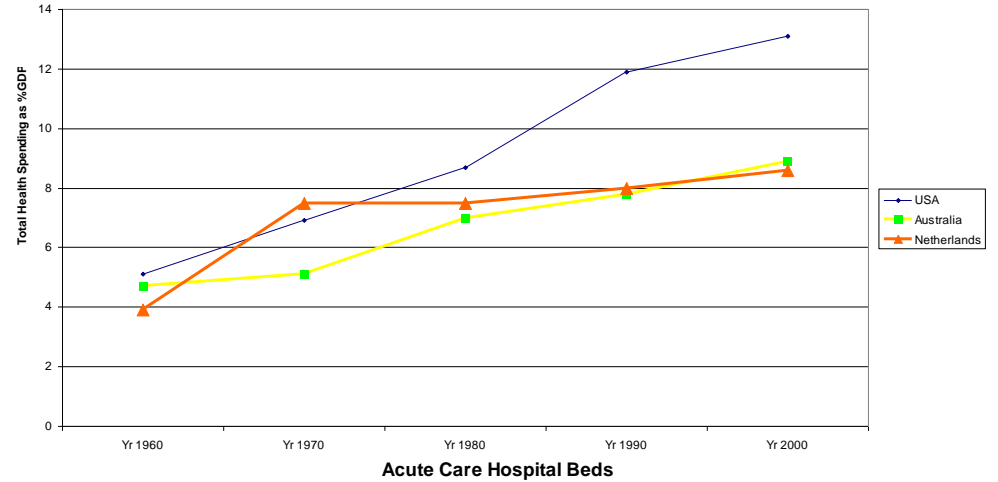
A comparative study in Australia and the Netherlands

- examined the practice of clinicians and managers tasked with the operational challenge of prioritising unplanned and emergency surgery.

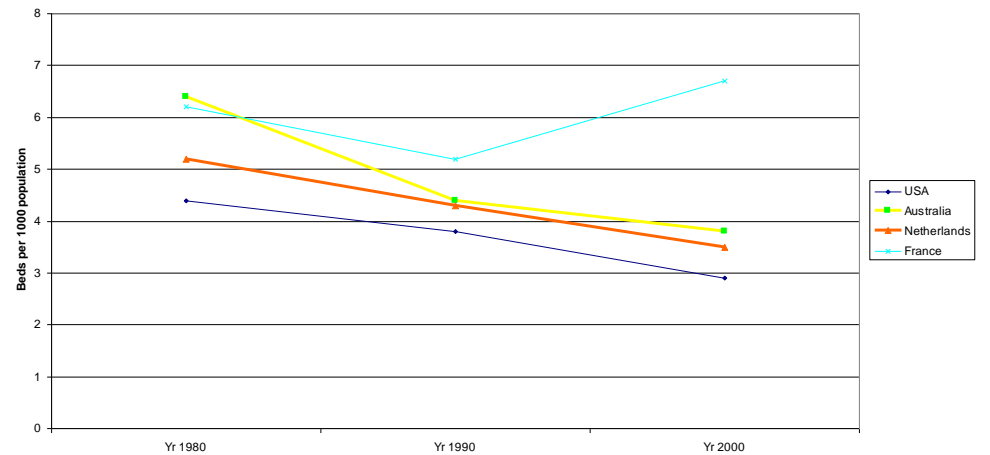
Different business models – same problem



Health Spending (OECD, 2003)



Acute Care Hospital Beds



Methods

Mixed method triangulation

- Survey instrument (in Dutch and English), SPSS analysis
- Recorded interviews, transcribed (in English), N-Vivo, Leximancer
- Observation

22 Australian Hospitals n =164

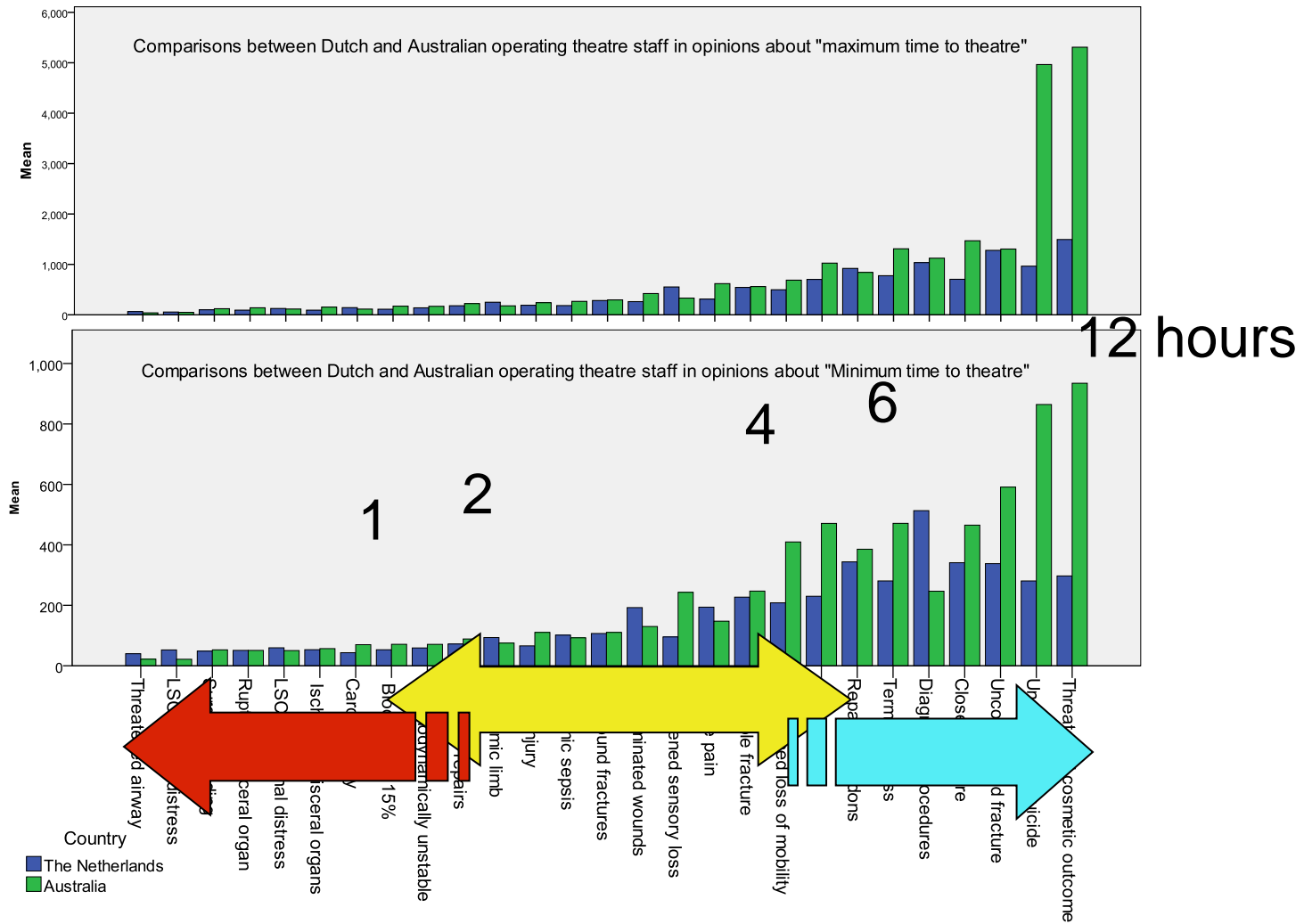
- Including tertiary metro, non-tertiary metro, and rural hospitals

12 Dutch Hospital n =144

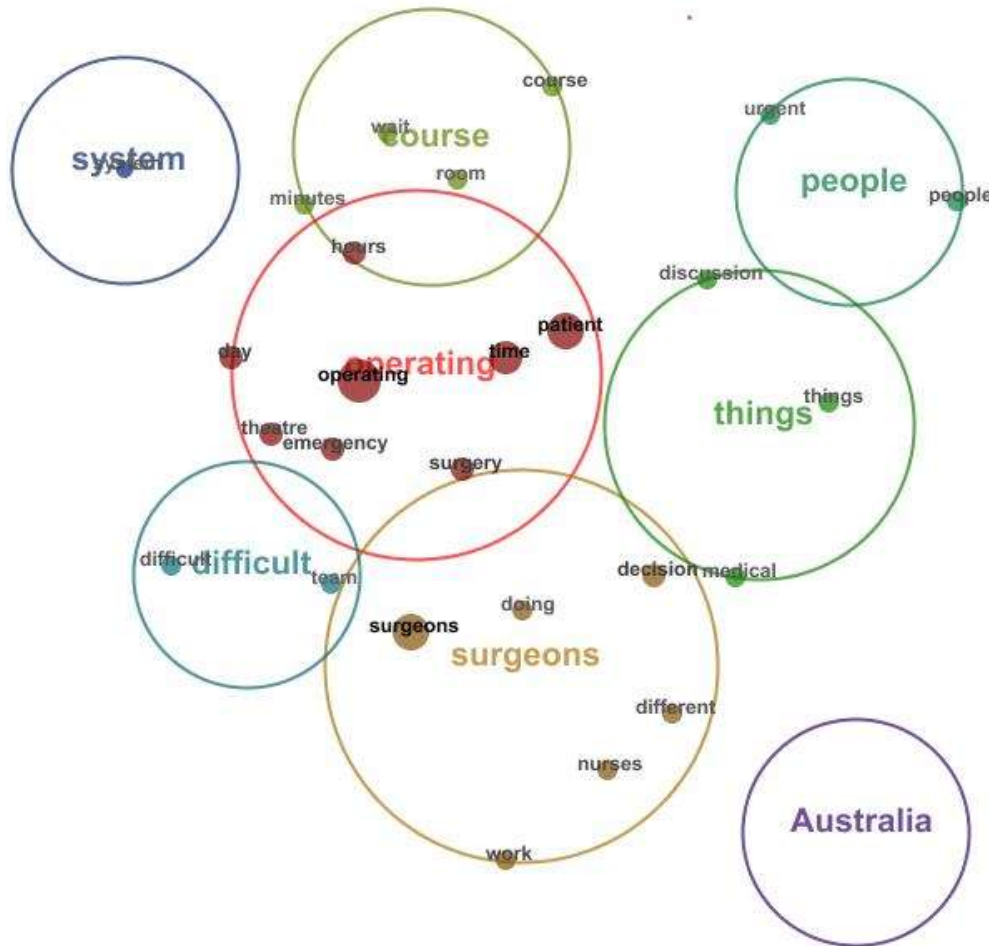
Survey: for a list of procedures or conditions; minimum and maximum acceptable delay:

- “Patient should be operated on within (...) minutes of presentation, and should definitely not wait longer than (...) minutes.”

Quantitative results – minimum & maximum acceptable delays



Qualitative results – semantic & thematic analysis



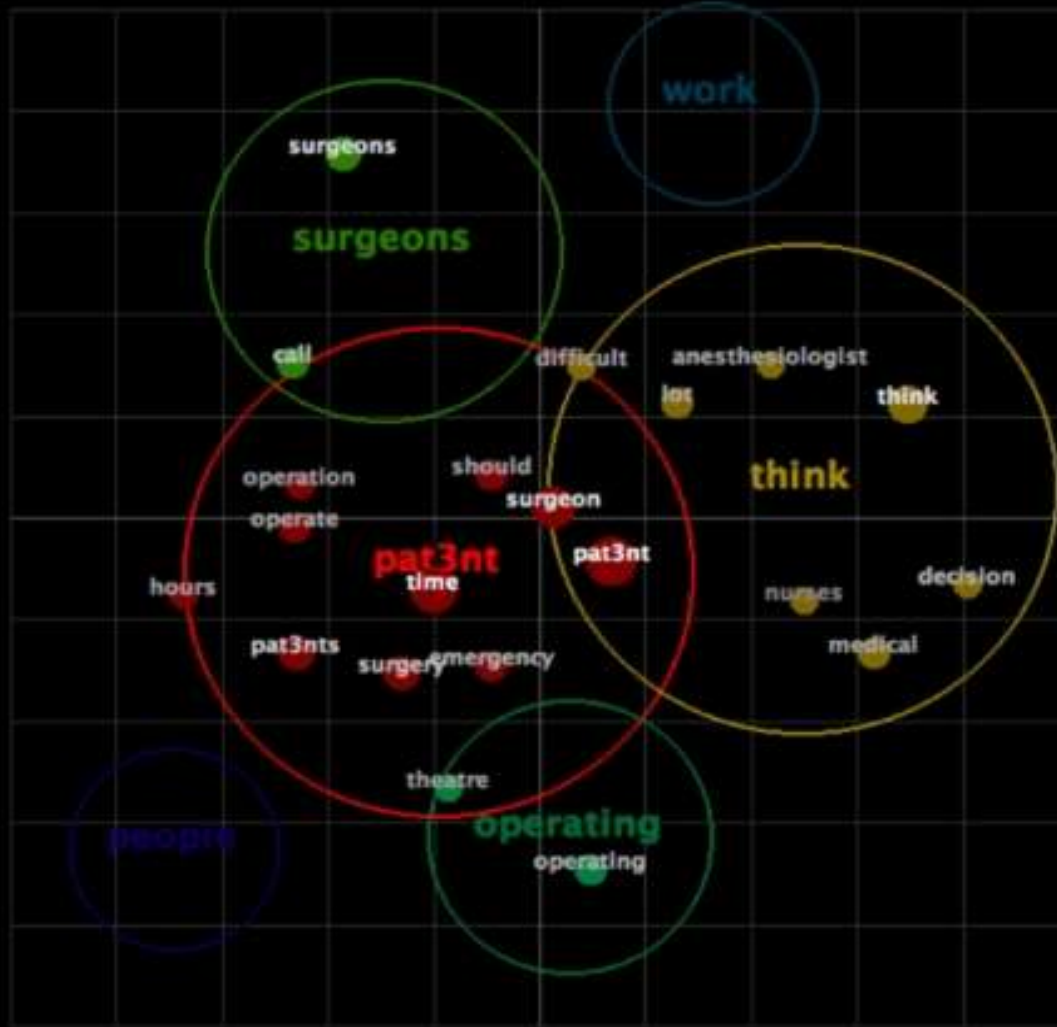
“We had **conflict** many years ago when there wasn't, when we hasn't [sic] team available for **emergency operations**. The complains of many **surgeons** was that the emergency **team** was always used by the general surgeon or by the neuro surgeon, because that the most cases, and the most emergency cases, at that we had lot of discussion from is it honest to have an a extra **team** for the emergency operations, because as a specialist had to keep sometime for that team.”

Yes. We had a **system** operate right away within one hour, within two hours, within six hours and after six hours; and we try to divided the patients. But we ask every time, “How long can you **wait**?”

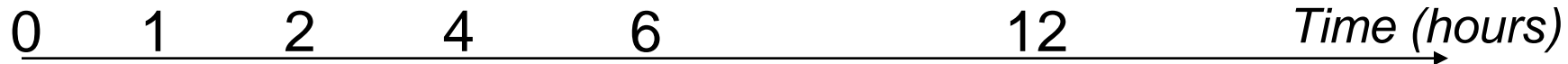
Now, well, they have the same authority in their function as the other ones, so they can do that. The **surgeon** in the **theatre** is not allowed to overrule.

Australia: Similar semantics and thematics

Iterations = 2000



Conceptual triage model



Urgency 1

Urgency 2

Urgency 3



<i>Consequence</i>	<i>Likelihood</i>		
	<i>HIGH</i>	<i>MEDIUM</i>	<i>LOW</i>
<i>HIGH</i>	HIGH	HIGH	MEDIUM
<i>MEDIUM</i>	HIGH	MEDIUM	LOW
<i>LOW</i>	MEDIUM	LOW	LOW

Operational / Logistic Determinants

Summary

Despite different business models, surgical service models in Australia and Netherlands are comparable.

In both countries queue position is determined by medical clinicians according to their indication of clinical priority.

Prioritisation tools were predominantly locally defined urgency categorical methods.

Logistical factors play a large role in scheduling and rescheduling emergency lists.

Paradigmatic differences between functional and professional positions contribute to tensions about clinical determinants.

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