ANZGOSA GUIDELINES FOR HOSPITALS AND/OR HEALTH SERVICES TO ASSIST IN CREDENTIALING OF SURGEONS PERFORMING GASTRIC CANCER RESECTION IN AUSTRALIA AND NEW ZEALAND 2013

Background

Major Upper GI and HPB surgical procedures are complex and carry significant risks of morbidity and mortality even in experienced hands. The published literature demonstrates a strong relationship between increasing hospital or institutional volumes and reduced mortality in all major oesophago-gastric and hepato-pancreato-biliary resections. There is also evidence that long term outcomes including overall survival are also improved. Not only are outcomes improved by increased individual surgeon volumes but specialisation of both the Surgeon and the unit has an important role to play.

Selection of suitable patients for surgery requires an assessment of fitness and multiple staging investigations to determine the extent of disease. The decision making involved in these patients is complicated and is best reviewed in a fully staffed and resourced multi-disciplinary team (MDT) meeting including the presence of surgeon(s), radiologist, medical oncologist, radiation oncologist in addition to a cancer nurse co-ordinator, allied health and other support staff.

The Australian and New Zealand Gastric and Oesophageal Surgery Association (ANZGOSA) is committed to promoting the highest standards of care for patients undergoing Gastric Cancer Resection in our Countries. The following are recommended ANZGOSA guidelines that may be used to assist hospitals and/or health services in their assessment of Surgeons wishing to perform Gastric Cancer Resection in their hospitals.

Initial Credentialing of Surgeons intending to perform Gastric Cancer Resections

Training requirements

Upper GI and/or HPB Surgery are subspecialties of General Surgery, which require additional post-fellowship training.

Individual Surgeons seeking credentialing for Gastric Cancer Resection must have completed:

1. Royal Australasian College of Surgeons (RACS) Fellowship in General Surgery (FRACS) or a recognised equivalent

AND

2(a) A recognised Post Fellowship Training Program in Upper Gastrointestinal Surgery.

The ANZGOSA Training Committee offers a 2 year Post-Fellowship Training Program in the surgical management of Gastric and Oesophageal disorders to successful applicants within Australia and New Zealand.
OR

2(b) The surgeon must demonstrate equivalent clinical training or experience in an established Gastric Cancer surgical centre and/or supervised practice for a minimum period of 1 year.

The assessment of training, experience and scope of practice should include:

- Letter, certificates or reports confirming satisfactory completion of post-fellowship training
- Surgical logbook demonstrating case-mix and experience
- At least two reports from referees, who are established, credentialed Gastric Cancer Surgeons and at least one report should be current from within the last 12 months of training.

Local Credentialing Committees should request advice from established, credentialed Gastric Cancer Surgeons.

Re-Credentialing of established Surgeons performing Gastric Cancer Resections

To maintain expertise and knowledge in Gastric Cancer Surgery, individual surgeons must:

1. Regularly perform Gastric Cancer Resections.

2. Regularly attend appropriate MDT meetings

3. Meet the RACS requirements for Continuing Professional Development (CPD) with specific attention to content relevant to Gastric Cancer Resection.

4. Demonstrate satisfactory ongoing performance of Gastric Cancer Resection based on peer reviewed clinical audit.

It is recommended that re-credentialing should be performed at regular intervals.

Other Considerations

Minimally invasive surgery requirements

With advances in technology many procedures can now be performed using minimally invasive methods including Laparoscopic Radical Total Gastrectomy and Laparoscopic Radical Subtotal Gastrectomy. Laparoscopic Gastric Cancer Resection requires greater expertise than open surgery and has lower margins for error.

Gastric Surgeons without specific training in Laparoscopic Gastric Cancer Resection should apply for extended scope of practice for introduction of a new procedure with the following considerations:

- Surgeons wishing to perform Laparoscopic Gastric Cancer Resection should demonstrate competence with a range of advanced laparoscopic procedures and with conventional Open Gastric Cancer Surgery.
- Initial cases should be appropriately selected.
- All cases should be subjected to clinical audit and review of outcomes

Hospital requirements

The surgeon must perform Gastric Cancer Resection in hospitals in which other major procedures are regularly performed, with ICU facilities, access to interventional radiology, interventional endoscopy, experienced nursing staff, 24 hour on site medical services, emergency theatre access, and senior surgical support.

MDT requirements

Cases for Gastric Cancer Resection should be reviewed at a fully staffed and resourced multi-disciplinary team (MDT) meeting and declared suitable prior to operation.

Gastric Cancer Surgeons should regularly participate in appropriate MDT meetings.

Audit requirements

Surgeons performing Gastric Cancer Resection must maintain an audit of outcomes. This can either be a personal or institution based audit.

Audits should include the minimum dataset as defined by the RACS.

Audit outcomes should include mortality, morbidity, length of stay, unplanned return to theatre, unplanned admission to ICU, unplanned readmission and overall survival.

In addition Gastric Cancer Resection specific outcomes including rates of Anastomotic leak and Duodenal stump leak should also be recorded.

Audit of outcomes must be peer reviewed, at least annually.

The ANZGOSA provides a secure, web-based database to assist its members in maintaining their own personal audit of Gastric and Oesophageal procedures.

References

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