



January - March 2006

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# Epworth broadens base with the acquisition of Freemasons

Epworth is set to become Melbourne's largest provider of private hospital beds following the successful signing of contracts to acquire Freemasons Hospital.

The inclusion of Freemasons will bring Epworth's overall bed capacity to more than 1150 beds.



*Signing of contacts 22 December 2005  
From L to R*

**Back Row:** Ray Horsburgh, John Maynard, Denis Hogg (Chief Executive Epworth), Barry Reaper  
**Front Row:** Bruce Bartrop and Brian Hamley

Epworth and Freemasons share a philosophy as not for profit, community focused hospitals. Freemasons is highly regarded in women's health, cancer and maternity services. The cancer services will complement those at Epworth Richmond and Epworth Eastern.

Chief Executive, Denis Hogg, says the acquisition is a unique opportunity to add obstetric services to Epworth's portfolio. Expansion and development of these services is planned.

Freemasons currently operates at two campuses at East Melbourne,

166 Clarendon Street and 320 Victoria Parade.

At the Clarendon Street site there are 161 inpatient beds, 5 operating theatres, an eight-bed combined Intensive Care and Coronary Care Unit with an additional separate 4 bed Telemetry Units and an Emergency Department.

Associated services on the site include MIA, EMROC and Melbourne Pathology.

Freemasons Medical Centre at 320 Victoria Parade incorporates the medical centre and day surgery and maternity units. The maternity department has 38 beds, 8 nursery beds and 6 delivery suites. There is a 30 bed day procedure centre with 4 operating rooms. The oncology

unit has 16 beds and there are clinic facilities and numerous consulting suites. One of the key partner services is Melbourne IVF.

### Freemasons services

- Women's and related health services including maternity, women's health and breast clinics, breast and gynaecological surgery and IVF.
- Surgical services including general surgery, urology, orthopaedics, plastic surgery, ophthalmology and ENT.
- Comprehensive cancer care covering diagnosis, surgical oncology, medical oncology, radiotherapy and chemotherapy

Freemasons admits approximately 27,000 patients per year and surgeons perform approximately 17,000 procedures. As well, there are approximately 2500 babies delivered each year.

Epworth plans to continue the operations of the Freemasons and to support doctors practising there. A review will be undertaken to ensure that the optimal level of care for patients and facilities for doctors are maintained and enhanced. This will provide an assessment of the potential gains that could result from amalgamating some of the services provided by both hospitals.

The proposed new name, Epworth Freemasons, will continue the unique personality of the Freemasons history, combined with Epworth's reputation of providing outstanding health care to form a great partnership.

Denis Hogg says the Epworth Foundation is committed to creating a seamless transition for all patients and staff, both, nursing and medical, in the process of incorporating Freemasons. " We want all staff and patients to know that at Freemasons it will be business as usual and that the changes will made as efficiently and smoothly as possible ", Mr Hogg says.

The Corporate Division of Epworth Foundation will provide services such as corporate affairs, financial, marketing and government relations, medical governance, health fund negotiation, risk management and legal issues. These key services support all Epworth campuses.

The acquisition will take effect once DHS regulatory requirements are fulfilled.

### Disclaimer

The views expressed on Epworth Clinicians Gazette are not necessarily those of the Editor or Epworth.

### Epworth Hospital

89 Bridge Road  
Richmond VIC 3121  
Tel: 9426 8622  
Email: jodie.bristow@epworth.org.au  
Web: www.epworth.org.au

## From My Desk

### New Honour Board at Epworth Richmond

Next time you are walking from the Erin Street direction towards Reception, stop and have a look at the new Honour Boards. These boards are a lasting acknowledgement of the substantial contribution made to Epworth by many individuals, families and organisations every year. Many of the major equipment purchases that keep Epworth at the forefront of technological innovation in medicine are made possible by the generosity of our donors.

### Using SMS

We plan to start trialling SMS text messages as a means of communicating quickly with clinical staff in appropriate circumstances. For example, we are launching a pilot to see whether texting anaesthetists about emergency cases will improve our access to anaesthetists out of hours. Messages might read something like "Appendix at 1800, call 94266271 if available". We also think this could be a useful way of informing surgeons and other staff regarding blood shortages.

### Thanks for the Feedback

Thanks to all of you who have given feedback after the last issue of the Clinicians' Gazette. We are constantly striving to increase and improve the clinical content and your feedback and contributions will help us make the gazette more useful. I appreciate the many comments, including the criticisms, of both the style and the content of the Gazette. Even the negative comments are welcome – at least it is being read!

### Labelling Errors

In the short space of four weeks recently Melbourne Pathology had to deal with seven instances of incorrect labelling of pathology specimens. Please be vigilant as the consequences can be severe. In the recent cases the consequences included the need for re-bleeding of patients (and explaining why – which doesn't do a lot for patient confidence). Other effects were that incorrect results were placed in patients' files and in one case there was confusion as to which results belonged to which patient. You can imagine the consequences if there were mis-labelling of a stereotactic brain biopsy specimen.

### Doctors Uncontactable

Sometimes doctors cover themselves for short absences. Recently one of our surgeons was at a one day conference not far from Melbourne and advised staff he would take calls direct from the ward. Unfortunately his mobile was out of range and he was effectively uncontactable for several hours during which time problems arose with his patient. Please keep this in mind if you also plan to take calls without designated backup. Even for short absences from Melbourne it is preferable that there be a clearly designated backup – otherwise you may leave our staff and your patient in a difficult and stressful situation.

### Gown and Gloves for VRE

Recently one of our surgeons refused to gown and glove when attending his patient with VRE (vancomycin resistant enterococcal infection). He did wash his hands on exit(!) I shouldn't have to ask but can we please comply with reasonable risk management practices even when it isn't convenient?

### Internet Access in Doctor's Lounge

The Senior Medical Staff Association lounge at Epworth Richmond is now fully commissioned and includes internet access as well as television and refreshments. If you are a member of the Association your security card should provide immediate access. If you are not a member and would like to join, please contact Alison Lodel on 9426 6357 and she will help you join for a very modest annual fee (which helps us maintain the medical library).

### Indemnity for Surgical Assistants

Please be aware that surgical assistants require medical indemnity cover in their own right. Even though an assistant may theoretically be indemnified under a surgeon's cover if acting on the specific instructions of the surgeon, there is still a risk that an assistant could be sued separate from the treating surgeon. The risks are low and so too are the premiums – so we insist that in all cases assistants have appropriate personal cover. This includes assistants at Epworth who may be fellows from abroad working in teaching hospitals who come over to Epworth to "give Mr Smith a hand".

### Anaesthetists and Abbreviations

One or two anaesthetists have the habit of using abbreviations instead of the full name of drugs when writing up drug charts. While it may be obvious to the prescriber, and even to nursing staff, it is unacceptable and would never withstand scrutiny in the event of a medication error. Please ensure that you write the full name of any drugs you prescribe.

### Transcribing System

We have been approached by SyberScribe, a company offering an over-the-telephone system of dictation with a promised 24 hour turnaround. If enough doctors feel the system would be useful we may proceed with implementation. If you think you would use a hospital-based system to dictate operation reports, discharge summaries or other letters, please let me know. If there are enough interested doctors we would organise a trial of the system early this year.

**Peter J Dohrmann**

*Executive Medical Director*

# Letter to the Editor

## Maxolon vs Zofran

I note with interest your recent article on this topic in the "Epworth Clinicians Gazette" in which you contrasted the expense of the "traditional prescription of Maxolon 10mg" with "the Rolls-Royce antiemetic Zofran".

I appreciate the concerns you expressed about the cost of antiemetic therapy. However, although it is attractive at a mere 28cents an ampoule, I doubt that more metoclopramide is the solution.

Decision making on the topic of postoperative nausea and vomiting (PONV) is difficult and often not helped by the literature on the subject. There are literally thousands of often poor quality papers of low power which produce ambiguous and conflicting results until they have been systematically reviewed, critically appraised, and quantitatively synthesized.

There are, however, a few outstanding papers which have done this and can guide a rational evidence based response to the issue.

Foremost amongst them are two by Martin Tramèr "A Rational approach to the control of postoperative nausea and vomiting: evidence from systemic reviews. Parts 1&2", published in 2001<sup>1,2</sup> and which have been the basis for a lot of subsequent material.

I draw heavily on those articles in making the following suggestions.

1. When looking at the cost of a treatment such as this the hospital should also consider the cost of no treatment or ineffective treatment. Just imagine the cost if just 1% of our enormous day surgery case load was admitted for a potentially avoidable side effect like PONV.
2. If we are going to use a "setron" we should use the cheapest in the lowest effective dose. They are to all intents and purposes of equal efficacy and interchangeable if not strictly equi-potent, but at \$5.35 per ampoule for granisetron and \$18.80 per ampoule for ondansetron not equal value for money. "The cheapest setron is the best setron"<sup>3</sup>.

It is obvious that ondansetron has become the default setting in this class of drug, almost a "generic". There is, for instance, no alternative routinely available on the anaesthetic trolleys. It might be that this could only be overcome if ondansetron is removed from stock for a period to ensure compliance and habit change. If practitioners insist they could/ should be asked to write a private prescription for it.

3. Encourage, educate or coerce the use of a rational evidence based approach to this problem. A three level strategy is proposed by Tramèr. In summary

- Reduce the baseline risk by such measures as reducing nitrous oxide use, avoiding neostigmine, using local anaesthetics wherever possible instead of opiates and using propofol for induction and maintenance of anaesthesia.
- Do not use routine preventative treatment as it does not work well, is less cost effective and unnecessarily exposes patients to the drugs.
- Identify the high risk patients and then use an effective drug combination.

The most important predictive factors are female gender, being a non-smoker, having a history of PONV and the use of opioid analgesics. Each of these increases the risk of PONV by approximately 20%. The type of surgery can also make a difference, for example urological or gynaecological surgery or if there is blood in the airway, as can the duration of surgery.

It has been shown that both dexamethasone and droperidol increase the efficacy of "setrons" and it is more effective to give a "cocktail" of prophylaxis. For example: steroid (dexamethasone 8mg) at induction and a 5-HT3 antagonist (ondansetron 4mg) with a D2 antagonist (droperidol 0.75mg) at the end of the procedure.

There is no evidence for an effect greater than placebo for metoclopramide.

4. To treat established PONV or as a "rescue" therapy low dose "setron" e.g. ondansetron 4mg (good for vomiting, less exciting for nausea) can be mixed with droperidol 2.5mg (the drug of choice for nausea) and diluted to 20ml in normal saline. This is stable out of the refrigerator for at least 8 hours. A dose of 0.1ml/kg can be given as a bolus as required 8 hourly. Dexamethasone 100mcg/kg can be added if considered necessary.

I really think that a strategy like this is more likely to deliver the outcome we want, that is it might work, and is likely to be more cost effective at the end of the day.

I can make available copies of the papers cited for distribution to the VMO anaesthetists or perhaps to circulate thorough PACU. The pharmacy might be consulted on sourcing the cheapest "setron" and making it available throughout the hospital. A protocol could be developed to make compliance with such a strategy easy for the end users.

I believe that we have an obligation to our patients to use the best available evidence to choose the best available treatments, eschewing the anecdotal and unscientific wherever possible. We also have an obligation to take into consideration the economic impact of our decisions. To meet these obligations we should aspire to adopt "best practice" wherever possible and offer a "Rolls-Royce" solution.

Sincerely

**Patrick Hughes VMO Anaesthetist**

<sup>1</sup> Tramèr MR. A rational approach to the control of postoperative nausea and vomiting: evidence from systematic reviews. Part I. Efficacy and harm of antiemetic interventions, and methodological issues.

*Acta Anaesthesiol Scand.* 2001 Jan;45(1):4-13.

<sup>2</sup> Tramèr MR. A rational approach to the control of postoperative nausea and vomiting: evidence from systematic reviews. Part II. Recommendations for prevention and treatment, and research agenda.

*Acta Anaesthesiol Scand.* 2001 Jan;45(1):14-9.

<sup>3</sup> Tramèr MR. (Editorial) Rational control of PONV - the rule of three/Le contrôle rationnel des NVPO - la règle de trios. *Canadian Journal of Anesthesia.* 2004 51:283-285

# Election of Representatives to the Medical Advisory Council

At the Annual General Meeting of Epworth's accredited medical practitioners held on 19th October, 2005, the election of the following representatives to the Medical Advisory Council for the next three-years was announced:

<b>General Medicine:</b>	<b>Dr Geoff Matthews re-elected</b>
<b>Gynaecology:</b>	<b>Dr Lynn Burmeister elected</b>
<b>Nephrology:</b>	<b>Dr Eugenia Pedagogos elected</b>
<b>Neurosurgery:</b>	<b>Mr Christopher Thien re-elected</b>
<b>Otolaryngology:</b>	<b>Open</b>
<b>Radiation Oncology:</b>	<b>Dr Gail Ryan re-elected</b>
<b>Urology:</b>	<b>Mr Jamie Kearsley elected</b>
<b>Vascular Surgery:</b>	<b>Mr Michael Denton re-elected</b>

Dr Ron Dick gave his Chairman's annual report, highlighting the governance challenges with the advent of Epworth as a multi-campus institution. He spoke in some detail of the work of the Medical Advisory Council which has considered and approved a number of key initiatives which will appear in the Clinical Governance Manual, due for release in 2006. He also spoke of the important relationship with the University of Melbourne and Royal Melbourne Hospital and of the likely increased role for Epworth in undergraduate and postgraduate medical education.

Mr Denis Hogg described the new organisational structure that has been implemented in the light of Epworth's transformation into a multi-campus organisation. He also noted that Australian private hospitals now provide some 32% of all hospital beds in the country and nearly 40% of all hospital admitted patients in Australia through 296 hospitals. It is interesting to note that of the top 10 treatments provided by both public and private hospitals, five are identical procedures, with private hospitals performing the majority in four of the five.

The guest speaker, Ms Leonie Young, Chief Executive Officer, Beyondblue: the national depression initiative, addressed the meeting on the topic of depression, and mental illness as a whole. The organisation's mission is to educate the community about the signs and symptoms of depression, reduce the stigma and discrimination for people with depression, encourage discussion and debate between those who collect the figures, those who report the facts and those with the illness, and provide the key conceptual background and the forum to stimulate this essential dialogue.

## News from the Medical Foundation

### 2004/5 Record Year

Thanks largely to a \$4 million donation from Tattersall's, the Medical Foundation was able to raise over **\$6.5 million** for the hospital during 2004/5. The Tattersall's gift was part of that organisation's \$5 million pledge for the Cancer Centre, paid out in full preparatory to Tattersall's public offering in July.

Committed Epworth donors and grateful former patients contributed a little more to the Foundation's annual giving appeals. And support from community groups such as Heartbeat also increased as did income from fundraising events including the Big Top Ball.

In the 12 months ending June 30, 2005, income from these sources reached **\$1,200,000**  
Of this:

- \$200,000 went to the Breast Service and was used to buy a Portable Ultrasound Machine, a Translucent Operating Table and other equipment
- \$100,000 went to the Intensive Care Unit and was used to purchase a High Capacity Ventilator
- \$260,000 was distributed to the Tattersall's Cancer Centre to help pay for the cost of equipping the Radiation Oncology Unit
- \$70,000 was used to purchase a LiteGait Partial Weight Bearing Device for the Rehabilitation Centre

- \$350,000 was recently donated to Emergency Department to be used to replace 10 patient monitors and 2 electrocardiograph machines
- \$110,000 went to Cardiac Services to form part of a \$1.3 million overhaul of patient monitoring equipment to be undertaken in August 2005
- the balance will be used to purchase a Multi-Purpose Computer-Guided Surgical System for the Musculoskeletal Research Centre.

### Recent fundraising milestones

The John D & Lyla Harris Foundation started by former Collingwood footballer John (Jiggy) Harris is to be wound up after having distributed several million dollars to worthy Victorian causes over several decades. And the trustees have decided that Epworth shall be the sole beneficiary of the funds available on termination, estimated to be over \$1 million, to go towards supporting the team working within Epworth's Acquired Brain Injury Unit.

BPW Transpec of Laverton North generously donated \$19,000 towards the purchase of a portable breast ultrasound unit for the Epworth Breast Service.

Each year, staff at BPW Transpec nominate a particular charity to which the company will make a donation. Upon hearing that the wife of their manager had been diagnosed with breast cancer, staff requested that a donation be made to the Epworth Breast Service of which Mrs O'Loughlin was a patient.



From L-R: Dr David Speakman, Mr & Mrs O'Loughlin and Dr Jane O'Brien.

The Hugh D T Williamson Foundation has made a 3-year pledge totalling \$100,000 in support of the Australian Institute for Robotic Research. The funds will be used to promote the use of minimally invasive robotic surgery and to evaluate outcomes and further applications for this revolutionary new form of surgery. Representatives from the Foundation visited the hospital on Thursday 22nd

September to view the Da Vinci robotic machine in action. A huge thank you to Mr Aubrey Almeida for taking the time to speak to the Foundation representatives to explain in further detail the capabilities of this amazing new technology.

And Phillip Webb Real Estate of Doncaster recently pledged \$100,000 towards the Epworth Eastern Day Oncology Unit becoming the first corporate donor to the Box Hill campus.

## Unhealthy Practices at Health Funds

**Hospitals should not be forced to cherry-pick profitable patients, writes Elliot Rubenstein.**

While we are deeply concerned about industrial relations legislation and threats of terrorism there are many other events we may barely be aware of that may have huge significance.

One of these is the behaviour of health insurance funds, which is well illustrated by Medibank Private. Last year this organisation announced an improved product called "Members Choice" which was a euphemism for reduced choice as it was going to reduce by 10 per cent the number of beds it would support.

Medibank Private began by asking hospitals to submit a "Request for (a contract I presume) proposal" which was to be assessed on the basis of value, price and commitment to quality and the like.

After considerable discussion and negotiation, three iconic not-for-profit church-associated hospitals were not offered full rebates for Members Choice subscribers. These are St Vincent's and The Mater in Sydney and Epworth Richmond in Melbourne.

Epworth has been offered a modified contract which allows it to charge patients \$80 a day for five days, after which Medibank Private will pick up the tab for an amount that is a little more than it was last year but not as much as CPI (which is less than the increase in the cost of supply health services).

It is necessary to know only a few facts to grasp the significance of this action, which will impinge on how, what, where and by whom private health cover is provided.

Epworth Richmond is a major hospital providing the full range of services including, among other things, a 24-hour emergency department, major services including neurosurgery and heart surgery and an intensive care unit.

Unlike some other hospitals, it has no admission bias towards more profitable procedures – "cherry picking" – but takes all comers. It runs to a tight budget designed not to make a loss.

Under the guise of "tackling the rising cost of benefits", Medibank Private is going to drive patients away from Epworth because it is offering a superior service. The fund has looked at Epworth and noted

that its costs are above average, so Medibank will save money by reducing the benefits it pays for its subscribers. If it is allowed to everyone back to average, we will end up with a less than average health service. But if it so damaged Epworth that it closed, Medibank really would save a lot of money. When an organisation takes action like this, using its massive strength against a body that is powerless at the negotiating table, one must wonder at the motives.

In the past four years, Medibank Private contributions to Epworth rose by 9 per cent; its premiums rose by 30 per cent. And the fund made a handsome profit – so it doesn't need to strangle some of the best hospitals in Australia to survive.

Medibank Private is not the only fund pressing hospitals. Axa is a publicly listed company and thus responsible to its shareholders. Despite making tens of millions of dollars profit through its health fund, previous known as HBA, Axa forces subscribers to pay a moiety of \$50 towards costs of accommodation for the first seven days at Cabrini in Melbourne.

The federal government owns Medibank Private. This should mean you and me. The government has said it is interested in selling the fund and no doubt wants it to have a solid bottom line.

What it has done is to show that health funds, which are supposed to offer us insurance against adverse health events, have the power, through the contracts they offer, to control the provision of services. It's another form of managed care, the application of business principles to medical practice.

As occurs with some health maintenance organisations in the US, funds could get to the point where doctors and patients would have to ring them for a clerk to organise where and when their procedures or admissions would take place.

Control hospitals, take doctors and patients out of the equation and we will see the end of a once great health system. Hospitals should not have to cherry-pick and health funds should not be allowed to.

*\* Elliot Rubenstein is a specialist anaesthetist at Epworth among other hospitals. Article published in Australian Financial Review, 8 December 2005.*

# Did you know... ?

Discharge summaries are essential for:

- a) The continuity and quality of patient care by acting as a means of communication for patients' local doctor, rehab service, nursing home etc and as a source of information for subsequent patient admissions.
- b) Accurate assignment of ICD-10 AM codes and the subsequent DRG that determines the funding for the hospital.

Epworth requires that a discharge summary be completed for EVERY overnight patient. Complete and specific documentation of all medical conditions and complications on the discharge summary will ensure that the hospital receives its full funding entitlement from the Health Funds. The following contain guidelines on how to complete each section of the discharge summary (MR4):

**PRINCIPAL DIAGNOSIS**

- The condition primarily responsible for admission after investigation.
- Record an uncertain diagnosis as "probable" if treatment was initiated.
- Do NOT state symptoms unless underlying cause not determined.
- Be as specific as possible, avoid terms such as IHD in favour of CAD.
- A procedure is not a diagnosis thus should not be listed under the Principal diagnosis heading.

**CO-MORBIDITIES**

- A condition or complaint that co-exists with the principal diagnosis.
- Clinical documentation MUST reflect how the condition affected patient management in terms of either treatment, diagnostic procedures, increased nursing care and/or monitoring or increased length of stay or it cannot be coded.
- Epworth discharge summary lists a number of co-morbidities. ANY box that is ticked must be substantiated by clinical notes in the body of the record.

**EPWORTH**  
Copy of summary to be sent to:  
 Self/Home  
 General Practitioner (insert on MR1)  
 Other treating doctor (insert form GP)

Unit Record Number: \_\_\_\_\_  
 Surname: \_\_\_\_\_  
 Given Name: \_\_\_\_\_  
 D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Medical Other: \_\_\_\_\_  
*Attach Patient Identification Label*

Separation date: \_\_\_\_\_  discharged  deceased  transferred to: \_\_\_\_\_  
**PRINCIPAL DIAGNOSIS:** the condition which after study was found to be responsible for the patient's admission

**CO-MORBIDITIES:** conditions present on admission and treated. These conditions resulted in a change to the patient's treatment / care / length of stay.  
 Anaemia  I.H.D.  Diabetes:  Type 1  Stable  Type 2  Unstable  
 C.C.F./L.V.F.  C.A.D.  Malnutrition  
 C.O.A.D.  Dementia  P.V.D.  Fracture:  Traumatic  Pathological  
 No Co-morbidities  Renal Failure: acute / chronic  Site/s \_\_\_\_\_  
 Other Co-morbidities (Please specify) \_\_\_\_\_

**COMPLICATIONS:** conditions which arose during the admission and affected the patient's treatment / care / length of stay.  
 Acidosis  DVT  Pulmonary Embolism  
 AF  Electrolyte Imbalance  Respiratory Failure  
 Anaemia  Specify \_\_\_\_\_  Septicaemia  
 post-haemorrhagic T.N  Pleural Effusion  Thrombocytopenia  
 Atelectasis  Pneumonia  UTI (specify organism)  
 Cardiac Arrest  Post-op haemorrhage / haematoma  Fracture (circle) \_\_\_\_\_  
 C.C.F./L.V.F.  Post-op wound infection  Trauma / Pathological  
 Decubitis Ulcer  Other Post-op complication  Site/s \_\_\_\_\_  
 No Complications  Other Complications (Please specify) \_\_\_\_\_

**PROCEDURES:** surgical / non-operative / diagnostic / therapeutic procedures which require anaesthesia / sedation / injected contrast

**ADVERSE REACTIONS / ALLERGIES (Please specify drug name, substance & reaction)**

**SUMMARY / ONGOING MANAGEMENT / FOLLOW-UP:** \_\_\_\_\_  
**DISCHARGE MEDICATION:** DRUG DOSE FREQ \_\_\_\_\_

**DOCTOR'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**COMPLICATIONS**

- Conditions that developed &/or occurred during the admission or resulted from surgical or medical care.
- State cause and effect e.g. Renal Failure due to surgery, Infection due to joint prosthesis.
- Epworth discharge summary lists a number of complications. Any complications that are ticked must be substantiated by the clinical notes in the body of the record.

**PROCEDURES**

- All significant procedures undertaken from the time of admission to the time of discharge should be recorded for coding.
- Document any procedure undertaken in theatre or imaging which required anaesthesia, sedation or injected contrast. This should include documentation of the approach of the procedure e.g. laparoscopic.
- Document the form of anaesthesia provided.
- Cancelled procedures should have the reason for cancellation documented.
- Procedures that could not be completed should be described to the extent carried out. Also document why the procedure could not be completed.

**Doctors Signature & Date**  
 Ensure the discharge summary is signed and dated once it is fully completed.

Lack of documentation in the medical record can potentially result in the hospital being underpaid for the work it performs.

For more information, contact Karinne Daley, Coding Co-Coordinator, Health Information Services on 9426 6599.

# Cycling Laos at 72



What inspires a 72 year-old retiree to partake in a 420 kilometre cycling tour through Laos over a ten-day period with CARE Australia Expeditions? When asked, Donald McKinnon, heart patient, intrepid traveller, boatman, loving husband, father of four, grandfather of seven, all round busy man says, "Why am I going to Laos? Do you know anything about the country? It looks beautiful. And I've always wanted an excuse to ride my bike more often!"

In December 1986 Donald McKinnon underwent serious heart surgery, courtesy of Drs John Fuller and Brian Buxton, constituting a five-graft bypass operation at Melbourne's Epworth Hospital. A long, slow recovery steered him back to health, a moderate diet (no full fat foods and definitely no pudding!) and a compulsory glass of good red wine each day keeps him well. But most importantly Donald has embraced the importance of daily exercise to maintain optimum health and sees it as an opportunity rather than a chore. He walks everyday, plays golf when time permits and swims in the surf every summer. This year, on his nineteenth anniversary as an Epworth heart patient Donald has been riding his bike every second day in training for a cycling tour in Laos.

To complete 420 kilometres through Laos, the group of cyclists (17 of them) need to average 80 or more kilometres per day on mountain bikes, which is about six hours of cycling, and some very big hills. But first, where's Laos? Laos, once a kingdom within French Indochina, is a small landlocked country bordered by Vietnam, Thailand, China, Burma and Cambodia. It has been a socialist republic since 1975. The Mekong River flows southeast from western China and along most of the border between Thailand and Laos and down into the South China Sea.

Intrepid Travel will fly the cycling tourists to Bangkok and then on to Chiang Rai, a bus transports the group to the border of Laos (Australians need a Visa to enter), and by day two of the tour they will enjoy a ride along the Mekong on a traditional rice barge. The group definitely hit the ground running, or cycling rather, when they arrive because from the moment these keen tourists get to Laos they are exposed to a wealth of Lao culture and exotic locales: jungles, rainforests, mountains, Buddhist Temples in Luang Prabang, caves in Vang Vieng, working elephants and water buffalo.

Day four will see the group in Pakbeng where they will take a boat and a bus to visit Hongsa, a very remote part of Laos where a CARE project is in operation, working to provide clean water, livestock and a regular supply of food to the Prai people. By day 10 the group will reach the

country's capital Vientiane, which has been influenced by an eclectic mix of Lao, Thai, Chinese, Vietnamese, French and Soviet architecture and culture. They will enjoy local markets, local people, local cuisine, and their last day will be spent back in Bangkok for some lively hustle and bustle before heading home to Australia.

It sounds a lot for anyone to take on but Donald sees the bright side, "It's not my heart I'm worried about, it's my puff!"

Fortunately there is some bus, barge and boat travel along the way giving participants a break from the bike seat. But in true spirit Donald is training hard every other day of the week. He began training for the trip back in June and gradually worked his way up to 40 kilometres per training day by increasing his distance by 10% each week. He now covers between 80 and 90 kilometres each training day and usually takes the Outer Circle bike track starting from Kew where he lives. Some days he will head toward the Gardiner's Creek track in Glen Iris, makes his way past the Monash Freeway into South Bank, along the light rail to Port Melbourne and then off toward Mordialloc. Here he stops to eat a packed lunch and drink lots of water and rest for a bit. Often the return trip is via Moonee Ponds and from here travels toward Merri Creek in Fairfield and winds around back to Kew. This session takes him up to five hours to complete. Most people just buy the Lonely Planet and read about their destination in preparation of an overseas trip. Why cycle when you can join a tour bus?

"I don't believe tour buses venture into these parts of Laos, the cycling is a Tourist Frontier." Says Donald.

"I liked the idea of preparing for it, the discipline of cycling to achieve a goal. Some people might think of it as one last fling before old age descends but really, all the training I've been doing has changed my mental attitude. It's shaken me out of getting old!"

Without too much paraphernalia and fuss Donald has acquired the essential cycling assets to make his peddling as comfortable as possible, lots of sunscreen, padded bike shorts and a very cool helmet that will surely help him up the hills. Good luck Donald and let us know how you go!

**Susannah Bond**  
Freelance Journalist



# The Epworth / Deakin Centre for Clinical Nursing Research

The School of Nursing at Deakin University and the Epworth Hospital have formed a collaborative partnership with a focus on clinical nursing research and education. The Epworth/Deakin Centre for Clinical Nursing Research provides academic and professional leadership to clinical staff and students of Epworth Hospital and Deakin University academic staff. The centre is committed to supporting innovative practice developments and improved patient outcomes. A major priority of the centre's activities is staff development through the provision of research training for nurses by participating in research, and academic supervision of higher degree by research candidates. The centre currently supports 4 PhD students and a Bachelor of Nursing (Honours) student. The main activities of the centre in 2005 have focused on developing a research program at Epworth Hospital, supporting quality and patient safety activities, and providing research training.

Professional development activities are provided through structured mentorship to: support and develop research activities, assist staff to present practice innovations at professional conferences and write for publication. In 2005, Melinda Turner presented at the Royal College of Nursing conference and the Scientific meeting of the Cardiac Society of Australia and New Zealand. In 2006, Susan Cartledge (BN honours student) will present a paper at the International Nursing Research Conference in York, UK. The clinical honours program at Deakin University is a very successful development that supports graduate nurses to integrate their graduate year at Epworth with the Bachelor of Nursing (Honours) degree.

The research program that is emerging at Epworth Hospital is the result of consultation and collaboration with the multidisciplinary staff

and is responsive to clinical practice issues and innovations. For example, current projects are mapping the trajectory of recovery of patients undergoing robot assisted cardiac and prostate surgery. We have a strong program of research in developing practice guidelines and investigating clinical environments for supporting families of critically ill patients and carers of chronically ill patients. The emphasis of research activities is to identify optimal methods for safe, effective management of patients and families to improve health outcomes.

In 2005 we have been pleased to welcome to Epworth several visiting colleagues from Denmark, Curtin University and Hong Kong Polytechnic. Torben Lauren, Deputy Director of Clinical Services and Connie Pederson, Head of Nursing visited Epworth from Gentofte University Hospital in Copenhagen to explore an exchange program between Danish and Epworth nurses. A second group of visitors from Viborg County in Denmark were interested in the model of academic and clinical collaboration established here at Epworth to foster clinical nursing research. We have been collaborating with our visitors to establish research links. In October, 2005 I was privileged to attend the graduation of the first cohort of Master of Nursing students in Denmark from the collaboration between Deakin University and the Viborg School of Nursing. During this visit, the first collaborative research project between the Epworth Clinical Nursing Research Centre and Viborg Hospital was launched. This project is titled "Pain experience and pain treatment of patients after surgery" and is funded by the Danish Medical Research Council. This research collaboration opens up many opportunities for clinical and research exchange between the Epworth and Viborg Hospital to enrich the practice experience of all involved.

*Professor Mari Botti*

## Developments in Medical Education

I would like to update you on recent developments in medical education at Epworth.

Staff have made very welcome, the final year University of Melbourne students from Royal Melbourne Hospital, who have rotated through our wards over the past two years. Their presence has clearly enhanced the experience for patients, nursing staff and indeed other staff across the campus, answering the concerns of a few members of staff who worried about possible negative reaction from patients. In future, an increasing proportion of post graduate specialist training is likely to occur in the private sector. This is because of the need to train more medical specialists, the inability of the public teaching hospitals to accommodate greater numbers of trainees, and recent recognition by government that many of the better established private institutions would be ideally suited to post graduate training.

Modern medical education is a continuum from under graduate through post graduate and then post fellowship through the various continuing professional development programs offered by universities and colleges. This concept implies a team approach, including academic input from universities and senior hospital staff and clinical input from experienced clinicians and more junior staff at the coalface. Registrars provide knowledge of the latest research developments and clinical trial results to compliment the depth of

experience provided by senior staff. Our students have commented very warmly of their experience at Epworth. Their only reservation has been the paucity of registrar staff on hand in the wards, to assist with their questions. In response to the Federal Government initiatives to move more specialist trainees into the private sector, Epworth hospital proposed a Federally funded pilot scheme, of placing more surgical and medical registrars into our wards. As discussed in previous gazettes, there is ample evidence to demonstrate that the presence of registrars in the wards improves patient safety and care. The presence of more specialist trainee registrars would offer both an improvement in clinical care for our patients and the ability for these registrars to assist teaching of the University of Melbourne medical students in the ward setting.

I am delighted to report that the Department of Health and Ageing in Canberra has responded to our request by agreeing to fund placement of medical and surgical registrars at Epworth Hospital on rotation from Royal Melbourne Hospital, with clearly monitored parameters, to further the Department's desire to achieve more training in the private sector and our desire to further enhance standards of care for Epworth patients and at the same time to further improve the experience for students in our wards.

*A/Prof Geoffrey Metz*

# Education

## Cardiac Meetings

Each Wednesday at 7:30am  
**Auditorium**

Breakfast is served from 7:15am.  
**For details of meetings:** Lisa Cahill ph. 9426 6690

## Emergency Department Meetings

Each Wednesday at 5:00pm  
**Emergency Department Clinical Room, Level 1, Erin Street**

**Enquiries:** Dr Allen Yuen ph. 9426 6340  
**For details of meetings:** Contact Heather Harvey ph. 9426 6284

## Epworth Rehabilitation Monthly In-service

Commencing 1 March 2006.  
 First Wednesday of each month at 3:30pm – 5:00pm  
**Auditorium**

**For details of meetings:** Judy Dungey ph. 9426 8769

## Forum Sessions

Commencing 17th February.  
 Each Tuesday at 5:45pm  
**Auditorium**

**Lecture 1** 5:45 – 6:45 pm.  
**Lecture 2** 7:00 – 8:00 pm.

**Enquiries:** Lisa Mollard ph. 9426 8504

## Melbourne Infectious Diseases Group

Meetings to be held at Epworth at 7:00am.  
**Auditorium**

Dates: 28 February, 14 March, 18 April 2006

**Enquiries:** Jack Richards email: cyberMIDG@mh.org.au

## Neuroscience/Radiology Meeting

Each Tuesday at 7:30am  
**Cato Room 1**

**Enquiries:** Mr Peter Dohrmann ph. 9427 0100

## Orthopaedic Meeting

Third Monday of each month at 7:30am – **Cato Room 1**  
**Presentation of Cases**

**Enquiries:** Mr. Martin Richardson ph. 9426 4333

## Physicians Meeting

First Thursday of the month at 6:00pm booked in **Meeting Room 1** except for the 6th April which will take place in the **Wesley Rooms 1 & 2**.

To confirm date and details of future meetings contact: Nadine Stacey ph. 9426 6589

## Respiratory Medicine Meeting

Commencing 6 February 2006  
 First Monday of each month at 7:30am – **Booth Room**

**Enquiries:** Dr Michelle Caldecott ph. 9246 6178

## Spinal Meeting

Commencing 3 February 2006  
 First Friday of each month at 7:30am – **Cato Room 1**

**Enquiries:** Dr Bruce Kinloch ph. 9246 8765

# Human Research Ethics Committee

The Epworth Human Research Ethics Committee provides guidance to the Hospital on recognized ethical principles and research conduct and makes recommendations to the Board of Management regarding all new research projects involving Hospital staff, accredited doctors and other allied health professionals and students, patients or volunteers.

During October, November and December 2005 the following projects were submitted and approved:

Is it safe to refer a patient with pulmonary embolism directly into Hospital in the Home for treatment within 24 hours of presenting to the emergency department?	Dr Michael Montalto Dr Benjamin Lui
A randomised controlled prospective multicentre trial comparing external anal sphincter repair with sacral nerve stimulation for treatment of faecal incontinence.	Associate Professor Joe Tjandra Dr Jane T Y Tan
Utility of isotope scanning co-registered with CT in the assessment of clinical problems in the human spine.	Dr Graeme Brazenor Dr Zita Ballok
Multicentre, unblinded, randomised, controlled trial to assess the effect of augmented versus normal continuous renal replacement therapy on 90-day all-cause mortality of ICU patients with severe acute renal failure.	Dr Benno Ihle Mr Michael Graan
A multicentre, randomised, placebo-controlled, double-blind, parallel-group, fixed-dose study evaluating the effect of one dose of rimonabant on glycemic control in type 2 diabetic patients inadequately controlled with insulin.	Dr Richard Simpson Ms Joanne Phillips
Investigation of a brief intervention to minimise alcohol use following traumatic brain injury.	Professor Jennie Ponsford Ms Laura Tweedy Dr Nicole Lee
Making IVF stimulation shorter.	Dr Gab Kovacs Ms Sheila Forde
Review of medication management of challenging behaviours during early recovery following traumatic brain injury.	Associate Professor John Olver Dr Frances Wise Dr Michael Ponsford

## @ Your Library

Have you visited the library recently? If not, you won't be aware of the exciting new database, MD Consult, which has been added to our collection.

The MD Consult database gives access, electronically, to more than 40 reference books, 40 medical journals and a substantial collection of clinics and yearbooks.

For doctors needing clinical images for presentations etc, there is a useful collection available. Also included in this database are practice guidelines and handouts for patients.

It's possible to search across all parts of the database simultaneously or to confine your search to a selected area such as reference books.

The home page offers briefings on the latest medical innovations and clinical trials.

If you have access to the hospital's Intranet, just go to Library and click on MD Consult to begin your search. If you would like to look at this database and you don't have access to the hospital's intranet from your desktop, please call into the library and use our resources.

The library is open 9.00am to 5.00pm Monday to Friday. Please call in or contact us on ext: 6134 if you have any queries about this database, or if you require help with locating any other information. We look forward to helping you.

## Newly Accredited Doctors August-December 2005

### Anaesthetics

BAKER, Alexander  
BUCHANAN, Frank Frederick  
CHIN, Richard Wee Chee  
DIACON, Mihaela  
GELDARD, Paul  
HEBBARD, Peter  
HOGG, Malcolm  
HOY, Christopher  
KLUGER, Roman  
KUMARASINGHE, Narathota  
LA FERLITA, Bradley  
LITTLE, Terence  
MCCUTCHEON, Craig Andrew  
ORME, Ruari  
ORR, Annabel  
PURCELL, Fabian  
SCHULTZ, Michael Owen  
SMITH, Richard  
VOSELIS, Rita Magdalene  
WATTS, Justin William  
WICKS Philip

### Cardiology

DE ZYLVA, Quintus  
FOY, Stephan  
HAMER, Angus  
PLATTS, David  
VOHRA, Jitendra  
YAPANIS, Anthony

### Emergency Medicine

FREWIN, Christine  
RAJEE, Manivannan  
SWAIN, Alexander

### Endocrinology

RANDO, Leo

### ENT Surgery

DOBSON, Michael Gibson

### Gastroenterology

BRETT, Andrew  
FRIEDMAN, Wayne  
NANDURKAR, Sanjay

### General Medicine

CHRYSOSTOMOU, Anastasia  
DE ZYLVA, Quintus  
HARLEY, Nerina  
SHAW, Peter  
LIM, Lyn-Li

### General Practice

MONK, Andrew

### General Surgery

BROUWER, Richard George  
MACKAY, Sean Desmond Patrick

### Gynaecology

AYTON, Rosemary  
JANSEN, Kym  
KRINS, Anthony Jacob  
MANOLITSAS, Thomas Platon

### Infectious Diseases

LEMOH, Christopher  
LIM, Lyn-Li  
STRATOV, Ivan  
WORTH, Leon James

### Intensive Care Medicine

CITRONI, Roberto  
HARLEY, Nerina  
NAGAPPAN, Ramesh  
SEET, Pi Ang  
WARRILLOW, Stephen Joseph

### Nephrology

CHRYSOSTOMOU, Anastasia  
FRAENKEL, Margaret Barbara  
HARLEY, Nerina  
LOH, Poh-Sien  
WOOD, Colin John

### Neurology

EVANS, Andrew Howard

### Oncology

CHIRGWIN, Jacquie Hope  
GAN, Hui Kong  
KENNER, David John  
ROITHMAIER, Sabine  
TONG, Michael Kin Pong

### Oral and Maxillofacial Surgery

RUTHERFORD, Nicholas  
SPENCER, Kevin

### Orthopaedic Surgery

GARD, Peter  
KHAN, Michael  
NATTRASS, Gary  
NORSWORTHY, Cameron  
PIANTA, Robert

### Otolaryngology

GUINEY, Patrick  
KENNEDY, Richard  
SIZELAND, Andrew

### Plastic Surgery

CAVALLO, Andrew Vincent  
KESARI, Jayashri  
LIEW, Gary Yeon Foh

### Psychiatry

HASSETT, Anne Maria

### Radiology

MAKHIJANI, Jagjeet Santii

### Respiratory Medicine

THIEN, Francis Thomas

### Rheumatology

FONG, Christopher

### Surgical Assistant

ANTANAITIS Vytautas  
BRENNAN, Janelle Patrice  
CHAN Jason  
CHEUNG, Philip  
ELLIS Gregory  
FINK Roy  
LEONG, Kenneth Chung Keat  
LIEFMAN Phillip  
LE PAGE, Philip Alexander  
MACKENZIE Alasdair  
MCKENZIE Robert  
MCRAE Donald  
MONK Andrew  
MUNDAY Nigel  
NGUYEN Bao  
NGUYEN, Brandon  
NIKFARJAM Mehrdad  
PAISLEY Anna  
PRANCKUNAS, Andrew  
REDD Crombie  
SAINSBURY David  
SHAW, James Michael  
SPARGO, Sarah Jane  
STATHAKOPOULOS George  
TREASE Larissa  
WONG, Anne Sweet  
WOOLVEN Benjamin

### Thoracic Surgery

BARLING, Andrew

### Urology

RULJANCICH, Paul John

### Vascular Surgery

CHARALABIDIS, Peter  
CHU, Peter  
HOLDAWAY, Damien