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1.0 **INTRODUCTION**

The Victorian Audit of Surgical Mortality (VASM) was established in 2008 to review deaths associated with surgical care in Victoria. The main focus of the audit is to observe, analyse and report on emerging trends in surgical mortality within Victoria. Each year an Annual Report is published and disseminated to Victorian Surgeons and Hospitals.

With the release of the 2010-11 VASM Annual Report an evaluation survey was sent to surgeons and hospitals. The survey sought feedback on the perceived value of the annual report, the Case Note Review Booklets (CNRB) previously published, the value of the personal feedback sent to treating surgeons as part of the peer review process and the value of the new electronic interface. There were also free text sections soliciting suggestions for improvement and requesting topics that might be addressed with future educational seminars. Surgeons were also asked if the outcomes from any part of the audit process had led to any change in their practice.

The questions directed to hospitals were similarly structured but limited to the perceived value of the CNRB and the Annual Report, and the general educational value of process.

There was a 15% response rate (162 out of 1093) from active surgeons canvassed and a 20% (24 out of 120) from participating hospitals. The return rates of evaluation surveys are good when compared to the Direct Marketing Association’s (DMA) 2010 Response Rate Trend Report.

2.0 **METHODS**

Data was collected between May 2011 and August 2012.

The questionnaires were sent to surgeons and hospitals (public and private) participating in the audit. The survey questionnaire was re-designed based on the 2010-2011 feedback, as shown in Appendix 1 and 2.

The responses to the questions assessing degree of support were presented as a five point Likert scale from 5 (strongly agree) to 1 (strongly disagree). There were also a number of questions requesting a descriptive response. The responses were analysed using thematic analysis.
3.0 **RESULTS**

In general the feedback received was positive. The outcomes from individual questions have been separated and presented in following sections.

### 3.1 **PERCEIVED OVERALL VALUE OF PUBLICATIONS**

The responses from both groups of stakeholders (surgeons and hospitals) suggest that the Case Note Review Booklet (CNRB) is seen as a valuable educational tool. The Annual Report is seen as informative.

*Figure 1. Perceived value of the Case Note Review Booklet (CNRB) and the Annual Report by surgeons and hospitals.*

**2010 - 2012 Surgeon evaluation**

**2010 - 2012 Hospital evaluation**

**Note:** 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

**Comments**

- Overall scores for perception of the (CNRB) as an education tool suggests strong support and indicates improvements during the audit periods.
- Overall scores for perception of the Annual Report as an informative publication suggest strong support and indicates improvements during the audit periods.
In terms of the Case Note Review Booklet (CNRB) the majority of surgeons (59% agreed and 24% strongly agreed) that the CNRB was a valid educational tool.

A small number of surgeons claimed that the CNRB was not useful (1% strongly disagreed and 3% disagreed).

Figure 2. Case Note Review Booklet evaluation for the period 2010-2012 - Surgeons.

The majority of hospital contacts (29% agreed and 67% strongly agreed) that the CNRB was a valid educational tool, its value has grown since 2010.

A small number of surgeons claimed that the CNRB was not useful (4% strongly disagreed).

Figure 3. Case Note Review Booklet evaluation for the period 2010-2012 - Hospitals.
In relation to the Annual Report, 99% of the 162 responding surgeons and 100% of the 24 responding hospitals returned an evaluation form providing feedback on the annual report.

Of the surveys received 77% of responding surgeons and 100% of responding hospitals were pleased with the current annual report and thought it was informative.

*Figure 4. Annual report evaluation for the period 2010-2012 - Surgeons.*

*Figure 5. Annual report evaluation for the period 2010-2012 - Hospitals.*
3.1.3 **VASM NEWSLETTERS**

The VASM newsletters are available for surgeons to view online by logging into the College webpage at [www.surgeons.org/vasm](http://www.surgeons.org/vasm). Of the 69% (102) of responding surgeons agree that the VASM newsletters are informative.

*Figure 6. VASM Newsletters evaluation- Surgeons.*

3.2 **PERCEIVED OVERALL VALUE OF SURGEON FEEDBACK**

In addition to the Case Note Review Booklet (CNRB) and the Annual Report, the surgeons were also questioned on their perception of the value of the personal feedback provided to them as part of the peer-review process.

*Figure 7. Perceived value of personal feedback from assessments.*

**Comments**

- The perceived value of personal feedback provided to surgeons by assessors during the peer-review process was generally viewed positively.
3.3 **VASM Audit Processes**

There was a high response rate from surgeons to statement 7 from the survey, “The VASM process helped improve surgical care at my institution/health service”, where 87% of the surgeons (141 of the 162) responded.

**Table 1. Comments made by the surgeons in relation to change in practice**

| The VASM process helped improve surgical care at my institution/health service (n=141) |
|---|---|---|
| **Response** | **Number** | **Percentage** |
| Yes | 66 | 47% |
| No | 75 | 53% |

From the group that responded “Yes”, all addressed that the VASM process helped improve surgical care at their institution/health service.

The major areas of change identified from 2010 were:

1) *“Management of peri operative anti-coagulation/anti-platelet therapy. Side effect of medications on operative tissues eg. FLOMAXTRA and the eye”.*
2) *“Rationalises the thought process – makes you aware of consequences of your action as a health care provider (surgeon in my case)”.*
3) *“Raised awareness of the importance of records”.*
4) *“Increased vigilance when dealing with the very sick patient”.*
5) *“Positive for risk assessment”.*
6) *“A constant example of the need to improve clinical practice”.*
7) *“Many facets of care closely monitored”.*

The major areas of change identified from this year were:

1) Increased awareness of potential clinical issues.
2) Improved communication.
3) Implementing systematic changes.
4) Changed audit perspectives.

The hospitals were also asked on how they perceived the overall value of the VASM audit, in which the majority agreed that the educational value of the audit had improved their surgical care.
3.4 VASM SEMINARS (2012 – FUTURE)

When the surgeons were asked to nominate topics for potential seminars to be hosted by the Victorian Surgical Consultative Council (VSCC) and VASM, the greatest interest was equally in “delay in diagnosis” and “communication issues” themes.

Figure 8. Seminar interests expressed by the surgeons and hospitals.

3.4.1 VASM/VSCC SEMINAR ‘MANAGING THE DETERIORATING PATIENT’

A seminar was held in collaboration with VSCC and VMIA on 23rd February 2012. The seminar was focused on recognising and managing the deteriorating patient as key components of safe clinical care. They form one of the top national priority areas of the Australian Commission on Safety and Quality in Health Care.

Evidence from incidents, clinical review of surgical care in Victorian hospitals and patient feedback has demonstrated the need to improve recognition and appropriate management of patients where their condition either progressively or suddenly deteriorates. Inadequate recognition and/or management of deteriorating patients are contributing factors in many adverse events in hospitals and health care organisations across the world.

Significant reductions in preventable deaths in health care can be achieved by introducing systems which facilitate early identification of the deteriorating patient. This involves clearly defined triggers, timely escalation of the matter and a pre-emptive approach to the management of the deteriorating patient to prevent further deterioration leading to adverse events.

Based on the experience of the VSCC, Department of Health Victoria, VASM and the Victorian Managed Insurance Authority (VMIA) the topics that were covered in the seminar included:

- The challenges to responding to the deteriorating patient.
- Auditing clinical deterioration - a sequence of events.
- Recognising surgical emergencies in ED or ward.
- Near-misses as viewed from the ICU perspective.
- Escalation and calling for help - before the MET call.
- Observation charts, triggers and communication.
- Patients and situations at risk in our public hospitals - Clinical Risk Management perspective on medical indemnity claims.
- Practical case solutions - panel discussion of typical challenges.

The seminar was attended by over 200 collaborators including surgeons, interns and HMOs, ED physicians, senior nursing staff, and hospital quality and safety officers.
3.4.2 Future Prospects

Seminar 2: Profiling the national accreditation advantages of the Victorian Audit of Surgical Mortality

The ‘Profiling the national accreditation advantages of the Victorian Audit of Surgical Mortality’ seminar is scheduled to be run in collaboration with VSCC and VMIA on 30th October 2012.

The National Safety and Quality Health Service Standards address critical areas that require improvements in healthcare.

The seminar is set to highlight how the VASM audit process is designed to attain information on factors involved in the death of patients undergoing surgical treatment, allowing the detection of emerging trends in surgical outcomes and to develop strategies to redress any system or process errors identified. VASM is a good tool that can help with some of the accreditation standards:

- Governance, review and reporting.
- Preventing and controlling healthcare associated infections.
- Clinical handover.
- Recognising and responding to clinical deterioration in acute health care.
- Preventing falls and harm from falls.

3.5 Electronic Dissemination

The overall value of moving to an electronic publication platform for all VASM publications (includes the VASM reports, the VASM newsletter and the CNRBs) was addressed.

55% (85) of surgeons agreed that the new electronic platform move adds value to the audit process.

Figure 10: Feedback received from the VASM survey regarding electronic publication platform - Surgeons.

The hospitals were also asked about the move to a fully electronic publication platform being of value and 53% of hospitals agreed with the move.
3.6 General Feedback

General feedback was provided to VASM from both hospitals and surgeons. There were comments left by 16% of the hospital stakeholders and 33% of the surgeons who returned the survey evaluation.

Comments were made on the following areas: improvements to the educational value, making audit participation compulsory, improving the information available to specialties, assessment issues raised, VASM improvements and process changes, changes to the case note review booklet and the online interface of forms and publications. (please refer to appendix 3 for full list of comments)

There were also suggestions that the assessment process could be accelerated so that feedback could be returned in a timelier manner.

Hospital comments received included to “provide regular reminders specially to smaller hospitals”, provide “specific details of cases referred from each hospital would be helpful, especially of any areas of concern”, and that the hospitals are unable to “access these electronic reports as I am not a member of RACS (as I am a quality officer not a surgeon)”.

Figure 11: Overall comment feedback received from the VASM survey.

4.0 Conclusion

The survey indicates general support for the VASM audit and its processes.

The major areas of change implemented as a result of VASM among surgeons were increased awareness of potential clinical issues, improved communication, implementing systematic changes and changed audit perspectives. The feedback in the VASM processes has suggested these areas could be improved.

There was significant interest by surgeons on seminars being presented by the Victorian Surgical Consultative Council (VSCC) and VASM. “Delay in diagnosis” received the most interest from the surgeons, which was followed by equal interest in “delay in diagnosis” and “communication issues”.

From all the surveys received, the majority agreed with the appropriateness of the VASM program.
Appendix 1. Evaluation survey sent out to the surgeons.

2012 VASM Activity Evaluation Fellows Survey

Thank you for participating in VASM. To improve disseminating VASM audit activities to you, please complete this survey.

1. The 2011 VASM Annual Report is informative.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Neutral
   - [ ] Agree
   - [ ] Strongly agree

2. The Case Note Review Booklet (CNRB) is a valid education tool.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Neutral
   - [ ] Agree
   - [ ] Strongly agree

3. The VASM newsletter is informative.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Neutral
   - [ ] Agree
   - [ ] Strongly agree

4. The VASM webpage is a useful resource about VASM.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Neutral
   - [ ] Agree
   - [ ] Strongly agree

5. The electronic platform, Fellows Interface, is valuable.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Neutral
   - [ ] Agree
   - [ ] Strongly agree
   - [ ] Not applicable

6. The assessor’s comments from the feedback letter is valuable.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Neutral
   - [ ] Agree
   - [ ] Strongly agree
   - [ ] Not applicable

7. The VASM process helped improve surgical care at my institution/health service.
   - [ ] Yes
   - [ ] No

   If yes, please specify:

8. The seminar ‘Managing the Deteriorating Patient’ was educational.
   - [ ] Strongly disagree
   - [ ] Disagree
   - [ ] Neutral
   - [ ] Agree
   - [ ] Strongly agree
   - [ ] Not applicable

9. The seminars that interested me are: Please tick all that apply.
   - [ ] Delay in diagnosis
   - [ ] Fluid balance/resuscitation
   - [ ] Delay in transfer
   - [ ] Deteriorating patient
   - [ ] Pre-operative management
   - [ ] Guidelines for assessments

   Other, please specify:

   □

10. VASM’s move to an electronic publications platform would be valuable. (Reports, newsletter, CNRB’s dissemination)
    - [ ] Strongly disagree
    - [ ] Disagree
    - [ ] Neutral
    - [ ] Agree
    - [ ] Strongly agree

11. Please provide any suggestions on ways to improve the audit activities.
    □

VASM thanks you for your participation in this important quality improvement initiative.

Please return all VASM correspondence to:
GPO Box 2821, Melbourne VIC 3001
email to: vasm@surgeons.org
or fax to: 03 9248 4159
Appendix 2. Evaluation survey sent out to the hospitals.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The 2011 VASM Annual Report is informative</td>
<td>□ Strongly disagree □ Disagree □ Neutral □ Agree □ Strongly agree</td>
</tr>
<tr>
<td>2. The Case Note Review Booklet (CNRB) is a valid education tool</td>
<td>□ Strongly disagree □ Disagree □ Neutral □ Agree □ Strongly agree</td>
</tr>
<tr>
<td>3. The VASM webpage is a useful resource about VASM</td>
<td>□ Strongly disagree □ Disagree □ Neutral □ Agree □ Strongly agree</td>
</tr>
<tr>
<td>4. The VASM process helped improve surgical care at my institution/health service</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>5. The seminar Managing the Deteriorating Patient was educational</td>
<td>□ Strongly disagree □ Disagree □ Neutral □ Agree □ Strongly agree</td>
</tr>
<tr>
<td>6. The seminars that interests me are: Please tick all that apply</td>
<td>□ Delay in diagnosis □ Fluid balance/resuscitation □ Pre-operative management □ Delay in transfer □ Communication issues □ Other, please specify:</td>
</tr>
<tr>
<td>7. VASM's move to an electronic publications platform would be valuable. (Reports, newsletter, CNRBs dissemination)</td>
<td>□ Strongly disagree □ Disagree □ Neutral □ Agree □ Strongly agree</td>
</tr>
<tr>
<td>8. Please provide any suggestions on ways to improve the audit activities</td>
<td></td>
</tr>
</tbody>
</table>

VASM thanks you for your participation in this important quality improvement initiative.
**Appendix 3. Comments made by hospitals and surgeons.**

<table>
<thead>
<tr>
<th>Improvements to the educational value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational case studies of 'what went wrong'; with targeted audience ie. General surgeons get general surgical case studies only</td>
</tr>
<tr>
<td>Excellent information. Thank you</td>
</tr>
<tr>
<td>Topics of interest for education: a) Interventional radiology b) definitive management of surgical complications</td>
</tr>
<tr>
<td>I feel that a direct approach is necessary to surgical and admin staff to stress the important finding that the clinical management might have been better in 35% of the audited deaths particularly delay in delivery of definitive care</td>
</tr>
<tr>
<td>My impression is that there is over-reliance on radiological colleagues where timely surgical intervention may have been life-saving</td>
</tr>
<tr>
<td>Support the process</td>
</tr>
<tr>
<td>Support for private hospital audit</td>
</tr>
<tr>
<td>I am happy with the current audit activities</td>
</tr>
<tr>
<td>Interesting that some of my colleagues don't wish to have anything to do with VASM and see it as an interfering pointless body. I take a contrary view to that</td>
</tr>
<tr>
<td>Thank you for your work and all the best to you Colin</td>
</tr>
<tr>
<td>This process adds little/anything to hospital audits - consider scrapping</td>
</tr>
<tr>
<td>Pretty comprehensive now - any more information increases the difficulty of assimilation of said information</td>
</tr>
<tr>
<td>VASM process provides valuable second opinions and peer review to uphold the best surgical practice</td>
</tr>
<tr>
<td>Helps in my self-audit process and enforces additional possibilities in our practice</td>
</tr>
<tr>
<td>It makes us all more aware of patients at risk</td>
</tr>
<tr>
<td>We have instituted rule that any ICU patient requiring surgery needs consultant (not just Fellow) present. Less mortality with consultant present</td>
</tr>
<tr>
<td>Keeping an eye on juniors especially early in year. Prophylaxis - antibiotics and DVT</td>
</tr>
<tr>
<td>Alerting potential pit falls. Never take things for granted</td>
</tr>
<tr>
<td>Information and methodology</td>
</tr>
<tr>
<td>VASM probably improves surgical care</td>
</tr>
<tr>
<td>Several cases seem to have avoided VASM somehow</td>
</tr>
<tr>
<td>Lead us to question why we are doing ops</td>
</tr>
<tr>
<td>Acting upon issues raised as systematic patient care issues</td>
</tr>
<tr>
<td>Improves awareness of problems</td>
</tr>
<tr>
<td>Promotes clinical discussion and awareness of adverse outcomes</td>
</tr>
<tr>
<td>Focused discussion on cases more closely</td>
</tr>
<tr>
<td>Has promoted discussion between surgical staff and anaesthetic staff as to how to reduce unnecessary delays in surgery</td>
</tr>
<tr>
<td>Improved patient care</td>
</tr>
<tr>
<td>Currently in progress following child’s death</td>
</tr>
<tr>
<td>More likely to be active in establishing definitive diagnosis of care</td>
</tr>
<tr>
<td>Increased institutional tendency to avoid 'higher risk' patients</td>
</tr>
<tr>
<td>Individual accountability highlighted</td>
</tr>
<tr>
<td>Promotes awareness of multiple problems in all specialties</td>
</tr>
<tr>
<td>It raises awareness</td>
</tr>
<tr>
<td>Procedures tightened, junior staff counselled</td>
</tr>
<tr>
<td>Increased awareness of how early mortalities can be made</td>
</tr>
<tr>
<td>Improved documentation</td>
</tr>
<tr>
<td>Although some of the feedback letters don’t seem relevant, it makes us look at our deaths on the unit more critically</td>
</tr>
<tr>
<td>Enabled surgeons to have a common platform on which to discuss difficult cases</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Prevention of possible mistakes, providing better care for patients</td>
</tr>
<tr>
<td>Incorporated into mortality review</td>
</tr>
<tr>
<td>Audit is essential for transparency of surgical activities</td>
</tr>
<tr>
<td>More awareness of events leading to poor outcome</td>
</tr>
<tr>
<td>Increased aged care services</td>
</tr>
<tr>
<td>Unsure but it should</td>
</tr>
<tr>
<td>My Fellow colleagues and I learn from the adverse events in these critical situations and make every effort to avoid the complications encountered by others</td>
</tr>
<tr>
<td>Helped streamline investigation and follow up</td>
</tr>
<tr>
<td>Encouraging other surgeons to participate</td>
</tr>
<tr>
<td>Has provided a platform for discussion at case care</td>
</tr>
<tr>
<td>The relevant findings formed part of the audit process</td>
</tr>
<tr>
<td>A form of external audit</td>
</tr>
<tr>
<td>Probable - but not proven</td>
</tr>
<tr>
<td>Increased consultant participation at operations</td>
</tr>
<tr>
<td>Draws attention to issues encountered by others</td>
</tr>
<tr>
<td>Probably yes, Hawthorn effect</td>
</tr>
<tr>
<td>Continuity of patients care and outcomes to improve future progress</td>
</tr>
<tr>
<td>On review of other's complications. I have adjusted my practice</td>
</tr>
<tr>
<td><strong>Making the participation compulsory</strong></td>
</tr>
<tr>
<td>Compulsory participation</td>
</tr>
<tr>
<td>Make it compulsory</td>
</tr>
<tr>
<td>Do I need to be in VASM + AVA audits?</td>
</tr>
<tr>
<td>It should be optional</td>
</tr>
<tr>
<td><strong>Improving the information available to specialties</strong></td>
</tr>
<tr>
<td>I would like to have access to better information for deaths in my specialty (ENT). i.e. all deaths, not just selected cases</td>
</tr>
<tr>
<td>Needs to be specific to each specialty</td>
</tr>
<tr>
<td>Subspecialty analysis would be valuable. The comments tend to be mainly focused on common cases - abdo surgery etc. My field (neurosurgery) has different concerns</td>
</tr>
<tr>
<td>I would like to have access to better information for deaths in my specialty (ENT). i.e. all deaths, not just selected cases</td>
</tr>
<tr>
<td>Express mortality with denominators in various specialties</td>
</tr>
<tr>
<td>It is of very limited value because I am a plastic surgeon and associated with virtually nil mortality</td>
</tr>
<tr>
<td>I am a specialist breast surgeon. I am continually asked to comment on general surgery cases which is inappropriate. Please amend your records</td>
</tr>
<tr>
<td>Small specialties with higher mortality rates due to the nature of their patients are overwhelmed compared to other specialties with low risk cases</td>
</tr>
<tr>
<td>A representative for general surgeons (?GSA) on the VASM management committee</td>
</tr>
<tr>
<td>More subspecialty relevance - better standard of care - more direction with pre/post op care</td>
</tr>
<tr>
<td>It would improve the surgical care at my institution/health service if there was one case which highlighted problems</td>
</tr>
<tr>
<td><strong>Assessment issues raised</strong></td>
</tr>
<tr>
<td>No surgeon should do more than 3 first line and more than 1 second line assessments per year</td>
</tr>
<tr>
<td>Auditors need to always apply clinical common sense in their assessments</td>
</tr>
<tr>
<td>We need a mechanism for disagreeing with the second-line assessment</td>
</tr>
<tr>
<td>The notes may not give a full impression of the complexity of a case</td>
</tr>
<tr>
<td>The process was too long for feedback on a case. Plus assessor’s feedback was not evidence based</td>
</tr>
</tbody>
</table>
I understand it takes time but for a 2nd line assessment the notes are not complete enough

I provide detailed reports that appear to be very superficially assessed - often by registrars! Hence the comment end up either stating the obvious or missing the point

### VASM improvements and process changes

It is one thing to collect data. Another entirely to perform root cause analysis and to correct underlying systemic problems in our hospitals. Unless VASM can do this, no improvement will occur

Focus on procedural and process issues

Too many reports on patients whose outcome would be unchanged. We learn little from them

Collect data on systemic problems in hospitals which contribute to mortality EG. access to the OR

No idea how VASM improves surgical care- we don't talk about it. Our CMO doesn't seem to know about the useful info

VASM focuses on mortality only, not adverse outcome. eg. Stroke after carotid endarterectomy, Amputation after lower limb bypass

All patient data in relation to deaths should be collected by independent person IE. College representatives or hospital employees other than treating surgeon. Data should not be submitted by treating surgeon

The process is flawed. Sending a UR number to a Dr with the onus on the Dr to chase up patient details - even if he/she never saw that patient - is an excessive waste of everyone's time. We already perform unit and hospital MTM review. This is excessive duplication - waste of time and money

Improve surgical care at my institution

Specific details of cases referred from each hospital would be helpful, especially of any areas of concern

Please provide regular reminders specially to smaller hospitals

### Case note review booklet changes

Keep the case book paper

Online interface of forms and publications

I am still struggling to access the database

The online assessors reports are problematic

Reliance in electronic contact is a possibility in implicating mortality

Have not been to the website

Prefer publications in paper form

Encourage as much electronic activity as possible. Congratulations upon all your efforts

Website can be hard to access from my laptop

"I am not able to access these reports as I am not a member of RACS (as I am a quality officer not a surgeon). If you want to use electronic publication of reports etc - you need to make them accessible to others who have an interest but are not surgeons."
VASM STAFF

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Claudia Retegan  Project Manager
Jessele Vinluan  Senior Project Officer
Karen Crowley   Project Officer
Mary Jane Sterry Project Officer
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