
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

MEDIA RELEASE



The Victorian Audit of Surgical Mortality – a continuing commitment to improved care

The 2012 annual report of the Victorian Audit of Surgical Mortality (VASM), a quality assurance programme aimed at the ongoing improvement of surgical care, was released today.

Funded by the Victorian Department of Health and managed by the Royal Australasian College of Surgeons, VASM involves the clinical review of all cases where patients have died in hospital while under the care of a surgeon. Cases notified to VASM are reviewed by at least one surgeon, practicing in the same specialty. These 'first-line assessors' are unaware of the identity of the treating surgeon, the hospital in which the death occurred or the name of the patient. Where there is insufficient information for the assessor to reach a conclusion, or if a more searching review of the case is felt to be necessary, a detailed case note review by another independent surgeon is done.

All but a very few Victorian hospitals providing surgical services have been recruited into the VASM process, and the number of Victorian surgeons actively participating has steadily risen to 88 per cent. In 2010 the Royal Australasian College of Surgeons determined that participation in audits of surgical mortality should be a required component of recertification in its Continuing Professional Development Program (CPD).

Thanks to the world class training and CPD of Australian and New Zealand surgeons, surgical mortality is very rare. An interrogation of the Victorian Admitted Episode Dataset (VAED) reveals that during the audit period a total of 2,400,542 patients underwent surgical procedures in Victoria.

VAED indicates that in a single year (1 July 2011 to 30 June 2012) 626,628 patients underwent surgical procedures in both the public and private sector. The number of deaths recorded by VAED was 1,995 or 0.3 per cent of patients who underwent surgery over this period.

The 2012 annual report contains clinical information on some 5,585 deaths reported over the last five years associated with surgical care and the outcomes of the peer review process in 2,862 of these. The balance of the cases is still in the process of review and will be included in next year's annual report. The annual report is sent to all surgeons and hospitals, and is available to the community on the College's website.

Among findings in the 2012 annual report:

- The majority of the demographic trends confirms previous years' findings that the majority of surgical deaths in this audited series occurred in elderly patients with underlying health problems, admitted as an emergency with an acute life threatening condition often requiring surgery;
- The actual cause of death was often linked to patients' pre-existing health status in that the cause of death frequently mirrored the pre-existing illness. Death was most often adjudged to be not preventable and to be a direct result of the disease processes involved, and not as a result of the treatment provided;

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- A detailed case note review, or second-line assessment, was deemed necessary in only nine per cent of audited cases. This is similar to the rate recorded in other Australian jurisdictions;
- Unplanned return to the operating theatre is often, but not always, necessitated by a complication of the initial procedure and is associated with increased risk of death. Consultant involvement in such cases is highly desirable. Direct consultant involvement continues to increase significantly with time;
- Since the inception of VASM, there has been a significant decrease in the frequency with which assessors are identifying clinical management issues. In 84 per cent (2,400) of audited deaths no, or only minor, issues of patient care were perceived. In almost ten per cent, moderate issues were identified. However, in 6 per cent of all cases, adverse events were identified;
- Concordance between treating surgeons and first and second-line assessors was as expected. Key areas of variance generally related issues of clinical management, with assessors perceiving there to have been more issues of clinical management involved. This is not an unexpected finding and supports the value of independent peer review;
- A series of workshops and seminars have been conducted by VASM as a result of the recommendations arising from the annual report. In one workshop VASM, in collaboration with the Australian Commission on Safety and Quality in Health Care, the Victorian Managed Insurance Authority, Victorian Department of Health and the Victorian Surgical Consultative Council, has highlighted the significant reductions in preventable deaths that can be achieved by introducing systems which facilitate early identification of the deteriorating patient. This involves clearly defined triggers, timely escalation of the case and a pre-emptive approach to the management of the deteriorating patient.

“The audit process is designed to monitor the system, address process errors and identify significant trends in surgical care,” the Clinical Director of VASM, Mr Barry Beiles said. “The audit enables surgeons and their employing hospitals to address areas of concern and to further refine and develop practices which are proving effective.”

“This is vital to improving the quality of healthcare in Victoria, and the Victorian Government is to be commended for providing the funding for this audit. VASM will continue to work closely with the Victorian Surgical Consultative Council, which reports to the state’s Health Minister, on issues of surgical care.”

All criticisms of patient management have been formally directed to the treating surgeons for their consideration. This feedback is essential to the audit’s overarching purpose – the provision of ongoing education to surgeons and the improvement of surgical care. VASM, like all audits of surgical mortality conducted by the Royal Australasian College of Surgeons, demonstrates an ongoing commitment to excellence on the part of its Fellows.

The VASM Annual Report is available on the College’s website: www.surgeons.org. Go to Research and Audit and click on Audits of Surgical Mortality (Victoria), Reports and Publications.

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