

Potentially avoidable urology mortality in Australia

Surgery in Australia and New Zealand is safe. The current rate of perioperative mortality is about 0.2%,¹ which is consistent with other leading developed countries. There is evidence that the Australia and New Zealand Audits of Surgical Mortality has contributed to the reduction in perioperative mortality since their introduction in the early years of this century.² The paper in the current journal investigating urology deaths reported to the Australia and New Zealand Audits of Surgical Mortality³ suggests that urological surgery is also safe (representing only 3.3% of all reported deaths) and the reported 11% of serious clinical management issues is consistent with the national data for all surgery.⁴

There are a few areas reported that are specific to urology – the devastating effect of sepsis in urological surgery is well recognized and it is disturbing that some deaths were related to failure to provide prophylactic antibiotics or to recognize urosepsis – but in the majority of cases the messages are those that are repeatedly reported to the Audits of Surgical Mortality from other specialties.

As doctors, we aim to provide the best possible care for our patients and the nature of surgery is that there will always be deaths related to comorbidities and emergency presentations, but improvements can still be made. The underlying messages from the urology data are: (i) there needs to be senior surgeon involvement in all aspects of perioperative care, (ii) communication within units, and between healthcare workers needs to improve and (iii) there needs to be more multidisciplinary involvement in patient care.

Senior clinician involvement would reduce the identified risks of inadequate preoperative assessment, criticisms of junior surgeons and delays in recognizing complications. Senior clinicians should also be actively involved in patient transfers. The authors have dedicated a section of their paper to communication issues which will potentially become more problematic as junior doctors move to shift work as opposed to ‘on-call’ rosters. Formal handovers, with protected allocated time, are essential.

Multidisciplinary teamwork has become the accepted norm for cancer care,⁵ but non-cancer decisions are still mainly left to individual surgeons, who may, in some cases, not be consultants. It would be far better that these important, and expensive, decisions were evidence-based involving acknowledged experts. Perioperative care is better delivered by a team approach, for example involving geriatricians, cardiologists and anaesthetists, rather than being left to surgeons. The assessment of surgical frailty is gaining

traction⁶ and the successful implementation of orthogeriatrics shows how perioperative care can change for the better.⁷

The Audits of Surgical Mortality continue to provide invaluable data that can support research projects such as that reported, in addition to the regular lessons published, in case review booklets and a web-based Case of the Month. One of the shortfalls of the audits is the lack of denominator for cases but this can increasingly be overcome by using the vast databases maintained by health departments documenting patient journeys through their admissions. Sharing and linking databases should be next step in detailing current deficiencies in mortality and morbidity and ultimately further improve patient safety.

References

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Philip McCahy,*†‡ FRCS (Urology), FRACS 

*Victorian Audit of Surgical Mortality, Royal Australasian College of Surgeons, Melbourne, Victoria, Australia, †School of Clinical Sciences, Monash University, Melbourne, Victoria, Australia and ‡Department of Urology, Monash Health and Central Gippsland Health Service, Melbourne, Victoria, Australia

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