

## Media Release

### **Audit finds surgery remains safe in Victoria despite significant decrease in presentations due to COVID-19**

**12 January 2022**

Surgery in Victoria remains safe with less than three deaths for every thousand procedures performed, according to the latest report from the Victorian Audit of Surgical Mortality (VASM) report.

The report contains clinical information on 9,638 surgical deaths that have gone through the full audit process since 2012.

It showed that the restrictions placed on elective surgery in both the public and private health sectors during the initial stages of the pandemic resulted in a near 10 per cent decrease in procedures performed in Victoria.

In total from 1 July 2019 to 30 June 2020, there were 660,583 surgical procedures in Victoria with 1,770 deaths reported to VASM representing a death rate of just 0.3 per cent.

Clinical Director of VASM, Associate Professor Philip McCahy said that he was pleased by the continued decline in surgical deaths in Victoria, and that the audit will prove to be a valuable resource in future years as the state recovers from the COVID-19 pandemic.

“It may be several years before the full surgical impact of COVID-19 is understood. There is evidence that COVID-19 infection has adverse long-term health implications. It remains to be determined if surgery in previously infected patients will increase the risk compared to those with no history of COVID-19”, Associate Professor McCahy said.

“While the coronavirus pandemic is ongoing, VASM is closely monitoring surgical deaths to assess any impact from COVID-19, and the audit will play a very important role in capturing this information in future collections.

“VASM continues to monitor trends in surgical deaths via independent peer-review assessments. The rate of preventable clinical management issues as identified by the peer-review process has decreased in the current audit period.”

“Despite this, VASM will continue its educational role in disseminating ‘lessons learned’ to clinical teams through educational events, case note review booklets, published scientific papers and hospital governance.”

“VASM’s role extends further by working more closely with the Victorian Perioperative Consultative Council. The current findings also outline key recommendations that reflect the National Safety and Quality Health Service Standards to enable health services to improve the quality and safety of surgical care in Victoria.”

Other key findings in Victoria demonstrated similar findings to the national audit. These include:

- The most common health risk factors related to cardiovascular, age and respiratory.
- The majority of surgical deaths occurred in elderly patients admitted as an emergency with acute life-threatening condition.
- There was a reduction in delay of surgical diagnoses.
- Increased appropriateness of DVT prophylaxis choice as perceived by the assessors.
- There was a reduction in clinically significant surgical infections.
- There was a reduction in clinical management issues that were preventable.

*VASM is managed by the Royal Australasian College of Surgeons and supported by Safer Care Victoria, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Australian Orthopaedic Association. All Victorian public and private hospitals providing surgical services are part of the audit process. In this year’s report, clinical reviews were completed on 1,061 cases where surgeons were involved in patient’s admission.*

The full report is available at <https://www.surgeons.org/-/media/Project/RACS/surgeons-org/files/surgical-mortality-audits/vasm/2021-12-08-VASM-Report-2020.pdf>.

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