ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

MEDIA RELEASE

FOR IMMEDIATE RELEASE: 1 August 2014

Surgical mortality report notes continuing improvement in surgical care

The Victorian Audit of Surgical Mortality (VASM) has released its sixth annual report as part of a quality assurance program aimed at the ongoing improvement of surgical care in Victoria. According to the report, trends relating to clinical risk management show overall improvements in patient surgical care.

Funded by the Victorian Department of Health and managed by the Royal Australasian College of Surgeons (RACS), VASM involves the clinical review of all cases where patients have died while under the care of a surgeon.

Cases notified to VASM are reviewed by assessing surgeons who are practicing in the same specialty but from a different hospital. The reviewers are not given any details about the treating surgeon, the hospital or the identity of the patient so that forthright assessment of each case can be conducted.

In this report VASM presents the outcome of reviews conducted into 3,948 deaths over six years from 1 July 2007 to 31 June 2013. During the audit period, a total of 3,306,147 patients underwent surgical procedures in Victoria. Any criticism of patient management raised in the report has been formally directed to the treating surgeon.

The VASM Clinical Director and practising surgeon, Mr Barry Beiles said that VASM has an independent data source, the Victorian Admitted Episodes Dataset (VAED), with which to compare surgical mortality rate and completeness of reported deaths.

“Both datasets show that surgical mortality is low (0.3%) and has fallen with each successive year, despite increasing numbers of operations being performed in Victoria,” he said.

Mr Beiles said that further developments with the new web-based electronic technology, to be introduced next year, would accelerate the reporting process.

The VASM peer review process is a retrospective examination of the clinical management of patients who died while under the care of a surgeon. Assessments consider whether the death was a direct result of the disease process or if aspects of the management of the patient may have contributed to the outcome.

“The VASM educational program aims to address deficiencies in clinical management and it is encouraging to note the decrease of these as progressive reports are published,” Mr Beiles said.

Media inquiries: Manager, Communications & Advocacy Department (03) 9249 1263

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RACS encourages participating stakeholders to further improve their leadership approaches to patient care especially around better documentation of clinical events, better communication between health professionals and improved clinical patient care management," the Clinical Director said.

"Most surgical deaths in Victoria are elderly patients admitted as emergencies and with other severe health problems. As we grow older we have more complex diseases and often more complex surgical procedures that could lead to complications," Mr Beiles said.

"Providing feedback in these cases is essential to the audit's overarching purpose, which is the ongoing education of surgeons and the improvement of surgical care for all patients."

ENDS:

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

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