ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

MEDIA RELEASE

Victorian Audit of Surgical Mortality released

Friday 19 February, 2010

The annual report of the Victorian Audit of Surgical Mortality (VASM), aimed at enhancing surgical care into the future, was released today.

VASM is a clinical review of those cases where patients have died in hospital while under the care of a surgeon. All 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 71 per cent.

Experience indicates that once an audit process is in place, the participation rate of hospitals and surgeons rises quickly. For example, in the case of Australia's oldest audit of surgical mortality, in Western Australia, the participation rate of surgeons has risen to more than 95 per cent since its inception in 2001. Participation in audits of surgical mortality is becoming a compulsory part of Continuing Professional Development requirements for Fellows of the Royal Australasian College of Surgeons.

The 2009 annual report covers the 18 month period up to 30 June. This report is sent to all surgeons and hospitals and is available to the community on the College's website.

Among findings in the 2009 Annual Report:

- The majority of surgical deaths in this audited series occurred in elderly patients with significant 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 a patient's pre-existing health status. Death was most often adjudged to be not preventable and to be a direct result of the disease processes involved and not the treatment provided;

- A detailed case note review was only deemed necessary in 12 per cent of audited cases. This is similar to the rate recorded in other Australian states; and

- Major concerns were raised regarding clinical management in four per cent of cases. However, in only four cases (0.6 per cent) were these felt to have definitely contributed to the likelihood of death.

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.

"This audit of surgical mortality will serve as a benchmark of sorts, enabling us in coming years to identify trends in surgical outcomes," the Clinical Director of VASM, Associate Professor Colin Russell said. "This has been the experience in other jurisdictions, enabling surgeons and their employing hospitals to address areas of concern and to further refine and develop practices which are proving effective."

Since the inception of the Western Australian Audit of Surgical Mortality all other Australian states have established their own audits, and the Northern Territory and the Australian Capital Territory are preparing to do so.

All of these audits are aimed at achieving continuous improvement in the delivery of surgical care, and reflect an ongoing and demonstrable commitment to excellence on the part of Fellows of the Royal Australasian College of Surgeons.

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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