ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

MEDIA RELEASE

The Victorian Audit of Surgical Mortality – an ongoing commitment to improved care

Friday 24 June, 2011

The 2010 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 89 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. In one single year, financial year 2009-2010, some 352,677 patients underwent surgical procedures in the Victorian public sector. The number of deaths attributed to surgery (2,551) is therefore a very small percentage of the number of patients who actually underwent surgery over the same period.

The 2010 annual report contains clinical information on some 1,886 deaths associated with surgical care and the outcomes of the peer review process in 1,113 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 2010 annual report:

- 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 their 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 the treatment provided;

- A detailed case note review, or second-line assessment, was only deemed necessary in 14.3 per cent of audited cases. This is similar to the rate recorded in other Australian states;

- 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 in such cases has risen from around 30 per cent in 2007-08 to 80 per cent in 2009-10. This is to be commended; and

- Since the inception of VASM, there has been a significant decrease in the frequency with which assessors are identifying clinical management issues. In the 2010 annual report there was a perception that clinical management might have been better in 395 of the 1,113 audited deaths. In only 47 of those cases, or 4 per cent of audited deaths, was clinical management deemed likely to have contributed to the adverse outcome.

"The audit process is designed to monitor the system, address process errors and identify significant trends in surgical care" the Clinical Director of VASM, Associate Professor Colin Russell 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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