



Fewer surgical deaths in Victoria over the past seven years

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The Royal Australasian College of Surgeons (RACS) has cited a significant reduction in the number of deaths of patients while undergoing surgery in both private and public hospitals in Victoria over the past seven years according to the 2014 report of the Victorian Audit of Surgical Mortality (VASM), released today.

VASM is collaboration between the Victorian Government's Department of Health, the Victorian Surgical Consultative Council and the Royal Australasian College of Surgeons. The VASM project is funded by the Victorian Department of Health and Human Services.

VASM Clinical Director, Dr Barry Beiles said that the aim of the program was the continual improvement in surgical care through an investigation into the deaths of patients.

Dr Beiles said it had an active participation rate of 97 per cent of all surgeons.

"The audit involves an impartial clinical review of all cases where patients have died in hospital while under the care of a surgeon.

"Deaths notified to VASM are reviewed by at least one surgeon, practicing in the same surgical 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 thorough review of the death is considered necessary, a detailed case note review by another independent surgeon is done," Dr Beiles said.

As part of the audit, VASM interrogated the Victorian Admitted Episode Dataset (VAED) to establish that during the seven year audit period 3,969,898 patients underwent surgery in Victoria (1 July 2007 to 30 June 2014), this resulted in the comparatively low number of 13,526 (0.3%) deaths (a reduction from 0.4% to 0.3% during the audit period).

Specifically between 1 July 2013 and 30 June 2014, 663,768 patients underwent surgical procedures; resulting in the comparatively low number of 1,924 (0.3%) deaths. These were primarily among elderly patients with pre-existing health conditions.

The report contains clinical information on 4,905 deaths that were associated with surgical care which have undergone the full peer-review process through VASM over the past seven years.

Among findings in the 2014 annual report:

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MEDIA RELEASE



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- Since the inception of VASM in 2007, there has been a significant decrease in the frequency with which assessors are identifying clinical management issues that contributed to the death of surgical patients. This is the result of a continuing improvement in surgical care.
 - Some of the main issues identified as areas for the improvement of surgical outcomes are the delays in treatment, particularly those admitted as emergencies with multiple comorbidities and the occasional decision where surgical procedures might have been avoidable. These issues will be at the forefront of VASM's ongoing educational initiatives.
 - Concordance analysis between the treating surgeons and assessors demonstrated that the assessors perceived more issues in clinical management than the treating surgeons. This shows the value of a peer-review process.

"All independent peer review assessments of patient management have been formally directed to the treating surgeons as part of the process to improve quality surgical care", Dr Beiles said.

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