

Surgical accountability: a framework for trust and change

The Western Australian Audit of Surgical Mortality is a prototype for a national scheme

Most surgical care is conducted to a high standard; when a death occurs under surgical care, the patient is usually elderly, with comorbid disease, and a gathering momentum of events leads towards death. However, this does not abrogate the need for accountability in the safety and quality of surgical care. Across the world, established programs promote a culture of reflective practice in surgery and anaesthesia^{1,2} which have been used as the basis for developing guidelines for perioperative care.³ For sustained accountability, programs require a high degree of perceived clinical ownership, confidentiality, safeguards for the process and participants (such as legal privilege), transparency, and a health care system oriented towards system improvement. Other requirements are robust quality assurance and safeguards to prevent suppression of process or practice failures, as well as full participation and complete data collection, with protected time for individual clinicians, if improvements in health care are to be facilitated.

In this issue of the Journal, Semmens and colleagues (*page 504*) report the successful transfer of an established program of auditing deaths after surgery from a public health care system in Scotland⁴ to a mix of public and private practice in Western Australia.⁵ While the long-term impact on surgical practice of the Western Australian Audit of Surgical Mortality remains to be determined, its reported early success merits reflection.

Although the WA audit was voluntary, participation was high (96%), as occurred in the Scottish Audit of Surgical Mortality.⁶ The proportion of patient reviews completed in WA (54%) should improve with time, towards the 91% achieved by the Scottish audit,⁶ although only 100% completion can give the assurance the public deserves. The finding of the WA audit that 6% of the people who died were patients of surgeons who opted out of the audit reveals another aspect requiring improvement if significant outliers are to be identified.

The “headline” finding in WA that 20% of surgery-related deaths were associated with deficiencies of care, with 5% caused by these deficiencies, and 2% considered preventable, exhibits a refreshing honesty on the part of participating surgeons. Technical errors featured prominently, in contrast to the process deficiencies identified in the Scottish audit.⁶ Of particular concern were the 24% of deaths that occurred after elective admissions (compared with 9% in Scotland), with a nearly twofold greater risk of having a deficiency of care in elective compared with emergency surgical patients. Furthermore, the finding that a consultant was the operating surgeon in 50% of cases, regardless of whether it was the patient’s first, second or third operation during the admission, is worrying, as subsequent operations are likely to be unplanned and to present complex challenges.

Surgical audits are not new to Australia — they can be traced back to the 1950s.⁷ Despite this history and the increasing audit requirements of the Royal Australasian College of Surgeons, a

recent national survey of medium-to-large hospitals revealed that over two-thirds of Australian surgical units did not conduct an audit according to College requirements.⁸ This failure was attributed to resource constraints. A method to measure the audit process itself, focusing on system issues as well as individual accountability, has recently been described.⁹

Although the surgical audit process has been slow to mature and progress in Australia, the WA audit model is a promising advance and is likely to contribute to improving surgical care in Australia and New Zealand, as it has done in Scotland.⁶ Involving other health professionals, such as anaesthetists and nurses,⁶ and using data from incident reporting systems,¹⁰ would further enhance the process.

Implementing an integrated national audit in individual states is a challenge. Meanwhile, the many doctors who have instigated, piloted and participated in the WA audit should be congratulated. So, too, should the Royal Australasian College of Surgeons for endorsing in principle the introduction of a surgical mortality audit based on the WA model across Australia and New Zealand.

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