Summary of the 1990 Report

(published April 1992)

Contents:

Sample group

The detailed sample for the 1990 Report was a randomised 20% of reported deaths, excluding children aged ten years or under.

Recommendations

- The provision of clinical and management information about patients, including postmortem records, needs to be improved significantly.
- Essential services (including staffed emergency operating rooms, recovery rooms, high dependency units and intensive care units) must be provided on a single site wherever emergency/acute surgical care is delivered.
- Decisions for or against operations should be made jointly by surgeons and anaesthetists; this is a consultant responsibility.
- The supervision of locum appointments at all grades in anaesthesia and surgery needs an urgent review.
- All grades of surgeon and anaesthetist should be involved in medical audit and continuing medical education.
- Efforts should be made to increase the number of post mortem examinations.

Key points

Information

There are examples throughout the report about deficiencies in the hospital notes; at least 90 cases could not be studied because notes were acknowledged to be lost. Operation notes were sometimes missing or lacking in essential details such as the name of the surgeon or the diagnosis; anaesthetic notes regularly failed to record physiological changes. Hospital notes about dead patients tend to be given a low priority by records staff and soon disappear and become difficult to find.

Essential services

Recovery rooms, high dependency units and intensive care units need not merely to exist as structures, they must also be ready for use. Proper equipment and qualified specialist staff (nurses, operating department assistants) must be available at all times if patients are to survive anaesthesia and surgery. If these services are not available patients may have to be moved elsewhere. Services were noted to be deficient, or closed, on Bank Holidays (particularly Christmas) and, perhaps surprisingly, at night. The proper and safe provision of pain relief after surgery implies that more high dependency units are required.

Emergency operating rooms

The provision of this essential service is important for all surgical specialities. Best results are obtained when there is no (non-medical) delay in the management of, for example, fractured neck of femur. If patients are to receive the greatest benefit from modern surgery it must be performed at the clinically most opportune moment. Dedicated operating rooms for emergency surgery are an essential service for all surgical specialities.

Split sites

The problems caused by the requirement for consultants (and their teams) to work and to be on call regularly on more than one NHS site are well known. The use of split sites should be historical.

Consultants

In this Enquiry, 83% of the decisions about surgery were made by consultants or senior registrars.

Consultant anaesthetists

About half the anaesthetics for the group of patients who subsequently died were conducted in the precise knowledge and (or) presence of a consultant. This proportion is not yet satisfactory but many of the deaths occurred as a result of factors outside the clinical responsibility of anaesthetists.

Speciality involvement

A few surgeons persist in occasional operating outside their primary speciality; this is deplored.

Locums

Temporary appointments are sometimes necessary. The most senior operating surgeon was a locum in 7% of the deaths; similarly, 9% of anaesthetists working alone were locums. Sometimes these locums of both disciplines were "acting up" but too often they admitted personally that they were inadequately trained or out of practice at particular procedures.

Non-medical assistance

The need for trained non-medically qualified assistants for anaesthetists is overwhelming; in 59% of deaths the anaesthetist was working without medical assistance.

Postmortem examinations

The infrequency of this useful investigation revealed in this Enquiry is to be deplored. Communication between pathologists (both hospital and Coroners') and clinicians is so poor that useful lessons can often not be learnt.

Non-trainee, non-consultant clinicians

There is evidence within this report that these clinicians (Associate Specialist, Staff Grade, Clinical Assistant) are sometimes isolated. Arrangements whereby these individuals are fully integrated into departments of surgery and anaesthesia need to be improved. This should include involvement in audit meetings.

Supervision

Trainee surgeons and anaesthetists need to be encouraged to request supervision. Consultants must ensure that trainees have the confidence to ask and to know that their request will not be rebuffed. If proper supervision of trainees is to be achieved, there may need to be more consultants, particularly in orthopaedic surgery and in anaesthesia.