Summary of the 1991/92 Report

(published July 1993)

Contents:

Sample group

The detailed sample for the 1991/92 Report was those deaths where the patient's final operation before death fell within the following group of surgical procedures:

- Amputation of whole or part of lower limb
- Surgery for strangulated hernia
- Colorectal resection
- Breast surgery
- Oesophagectomy
- Pulmonary resection
- Coronary artery bypass graft(s)
- Hysterectomy
- Prostatectomy
- Craniotomy
- Primary elective total hip replacement
- Surgical management of burns
- Any oral/maxillofacial surgery
- Any otolaryngological surgery
- Any ophthalmic surgery

Recommendations

- The medical Royal Colleges and the Specialist Societies in Surgery, Gynaecology and Anaesthesia must encourage all consultants to participate in the National Confidential Enquiry into Perioperative Deaths. Full co-operation would enable the profession to defend itself against charges of falling standards and lack of public accountability. The failure of some consultants to return questionnaires is unacceptable and a cause for concern.
- Surgeons, gynaecologists and anaesthetists need to address the continuing problem of thromboembolism which causes death after surgery. We have emphasised this matter before and we regret that we must again bring the profession's attention to it. Hospitals and clinical directorates should be required to address the issue and develop an agreed local protocol: every consultant should then follow this protocol. The research bodies and the Department of Health need to continue actively to encourage and support research in this field.
- All grades of surgeon, gynaecologist and anaesthetist must realise the critical importance of fluid balance in elderly patients.
- There needs to be a collaborative approach to the matching of surgical and anaesthetic skills to the condition of the patient.
- Surgeons, gynaecologists and anaesthetists must have immediate access to essential services (recovery rooms, high dependency and intensive care units) if their patients are to survive. The previous Reports have emphasised the need to have emergency operating and recovery rooms available 24 hours a day.
- It is no longer acceptable for basic specialist trainees (senior house officers) in some specialities to work alone without suitable supervision and direction by their consultant. Managers and consultants must locally achieve these arrangements.
- The postmortem rate is too low. At least 49% of postmortems demonstrate, despite clinicians' scepticism, significant, new and unexpected findings that are relevant. Postmortems are an important form of quality control.
- The necessary information available within the NHS under the present system is inadequate. Despite our repeated comment about this, we are still unable to obtain basic and timely data about the numbers of patients who have operations and the number of perioperative deaths. There is a need for an improved method for collection and validation of information on perioperative deaths locally and nationally.

Key points

Management

- Managers must realise that there are resource implications for a service that is increasingly consultant-based.
- Managers should urgently review the storage and retrieval of medical notes.
- Managers should assist local reporters to identify methods of reporting all relevant deaths.
- Data on the number of surgical procedures performed and the number of perioperative deaths will be inadequate until a unique patient number is in general use in all medical records.

Surgery

- Surgery should be avoided for those whose death is inevitable and imminent. A more humane approach to the care of these patients should be considered; these decisions should be directed by consultants.
- Specialist opinion should be sought before undertaking some procedures (e.g. amputation, oesophagectomy, hysterectomy, craniotomy).
- Resuscitation and preparation of patients for surgery should not be inadequate or hasty (e.g. strangulated hernia).
- There is a need for more consultant involvement in the theatre, particularly for emergency cases (e.g. colorectal resection).

Anaesthesia

- Arrangements whereby anaesthetists could work in teams (with other anaesthetists) should be considered.
- Anaesthetists should review their practice of non-invasive instrumental monitoring at induction of anaesthesia.
- The potential for local protocols or national guidelines for staff-patient matching, the use of anaesthesia teams, the provision of essential services, the transfer of patients and other matters should be realised.