Summary of the 1993/94 Report

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Sample group

The detailed sample for 1993/94 was the first perioperative death reported for each consultant surgeon or gynaecologist.

Recommendations

- Consultation, collaboration and teamwork between anaesthetists, surgeons and physicians should be encouraged and should be the usual practice.
- Surgical management should be planned and should include all those provisions that are required for good outcomes.
- The availability of staffed (medical, nursing and ancillary) emergency operating theatres on a 24-hour basis is essential; Trusts admitting urgent and emergency cases must ensure that they are provided.
- The elderly and unfit constitute a large proportion of the workload; improved perioperative management is required to ensure that their care is appropriate.
- Protocols for the treatment of common conditions should be applied more widely to both elective and emergency admissions, and should be subject to audit.
- Continuity of care after operations is essential; local arrangements must ensure that it occurs.
- The roles and responsibilities of all doctors need to be more clearly defined nationally, and implemented locally.
- Clinicians and Coroners should make strenuous efforts to improve their local working relationships.
- Systems should be implemented by Trusts to improve the retention and availability of all notes and records of clinical activity.
- Trusts need to encourage more participation in clinical audit.
- More research is required on thromboembolism prophylaxis.

Key points in anaesthesia

- Surgical operations should not be started in hospitals without appropriate critical care services.
- Serious sepsis is a frequent factor in perioperative deaths.
- Anaesthetists must have appropriately skilled and dedicated non-medical assistants.
- Consultation between surgeons and other specialists, including anaesthetists, needs to be more frequent in order to promote a team approach.
- A team approach with direction from consultants would facilitate optimal management in vulnerable patients.
- The roles and responsibilities suitable for staff grade anaesthetists need to be defined and implemented.
- Two thirds of locum 'trainees' were not in a recognised training programme.
- The use of protocols in the management of certain clinical conditions needs to be increased.

Key points in individual surgical specialties

Cardiothoracic surgery

- At least 98% of operations were carried out by a senior surgeon.
- The principle of continuity of care in dealing with postoperative complications needs re-emphasis.

Colorectal surgery

- Right hemicolectomy is a more dangerous operation than is widely perceived.
- There was inadequate provision of high dependency services for patients after colorectal surgery.
- Mechanisms should be in place to ensure that routinely used protocols for thromboembolic prophylaxis are also applied to urgent and emergency admissions.
- Postmortem examination reports (both hospital and Coroners') must always be available to clinicians.

General surgery

- There was a high level of senior involvement in the preoperative decision-making process, but collaborative care ought to have been developed further for high risk patients.
- Some patients should have been referred to more specialised surgeons, and to hospitals where ICU/HDU facilities were available.
- Many patients were in poor condition at the time of surgery as a result of their presenting disease, their age and co-existent diseases.
- Up to 35% of the operations were done out-of-hours.
- All infants under the age of six months in this sample were treated in a specialist unit.

Gynaecology

- The decision to perform surgery inpatients with obvious gynaecological malignancy should be made on an individual patient basis, ideally by a gynaecological oncologist.

- The level of audit and the number of post-mortem examinations need to be increased.

- The efficacy of prophylaxis against venous thromboembolism and infection needs to be evaluated.

Neurosurgery

- Neurosurgeons had the lowest response rate to questionnaires.

Ophthalmic surgery

- Rates of clinical audit and postmortem examination were too low in this specialty, and need to increase.

Oral/Maxillofacial surgery

- There was a low rate of clinical audit in this specialty.

Othopaedic surgery

- Seventy-five percent of the deaths in this sample followed femoral neck fracture.

- There remain considerable organisational problems in dealing with increasing numbers of elderly unfit patients.

- The role of chemical prophylaxis in venous thromboembolism remains uncertain.

- There was an inadequate provision of critical care services for these patients.

- The low rate (26%) of operations performed by consultants is clearly unsatisfactory

Otorhinolaryngological surgery

- Senior surgeons had operated on 87% of the patients in the sample.

- Patients with respiratory problems should receive adequate preoperative chest assessment and appropriate postoperative treatment.

- Deaths after epistaxis are more common than is generally supposed.

- There was an inadequate provision of HDU beds.

- The level of clinical audit was low and unsatisfactory.

Plastic surgery

- The operative procedures illustrate the wide range of cases under the care of plastic surgeons. Nine of the procedures were for major malignancies of the head and neck, and one for malignant melanoma.
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- All patients received the specialist care of a plastic surgery team.

Urology

- There was a high (97%) consultant input in decision-making.

- Eighty-nine percent of patients were over 60 years of age.

- Fifty-six percent of patients were in ASA classes 3 and 4.

- The value of prophylaxis against venous thromboembolism is uncertain in urology and deserves further investigation.

- The rate of postmortem examination was unacceptably low.

Vascular surgery

- Thirty-six percent of emergency or urgent vascular surgery in this sample was done by surgeons with no regular vascular practice.

- Surgeons managing acute limb ischaemia must have the support of vascular interventional radiologists.

- Any hospital receiving major vascular emergencies or trauma must maintain an immediately available on-call surgical team, and must have adequate ICU/HDU services.

Anaesthetists should be fully involved in the care of vascular patients, particularly those undergoing embolectomy, when this is being done with local anaesthesia or sedation.

Key Points in Pathology

- The number of postmortem examinations performed was too low.
- The overall quality of postmortem examinations was generally satisfactory; early signs of improvement following the publication of the Royal College of Pathologists' "Guidelines for Post Mortem Reports" were evident.
- Communication between surgeons and pathologists was sometimes poor.
- Pre-printed formats for postmortem reports are undesirable since they limit the space available for description and interpretation. Flexible pre-formatted frameworks on word processors are recommended.
- There should be greater adherence to the standard format of the death certificate. Some clarification of the guidelines is needed.
- A clinico-pathological correlation should be included in all postmortem reports.
- Introduction of a system of audit, which includes Coroners' postmortem examinations, should be considered.

General data issues

- Non-availability of medical notes continues to be a major problem.
- Some reporters were unable to provide data to NCEPOD in time for their hospitals to be included in the detailed sample.
- There were wide regional variations in return rates of questionnaires.