

# General/vascular surgery



## Individual Consultant SASM Report for Mr X

### Table of Contents

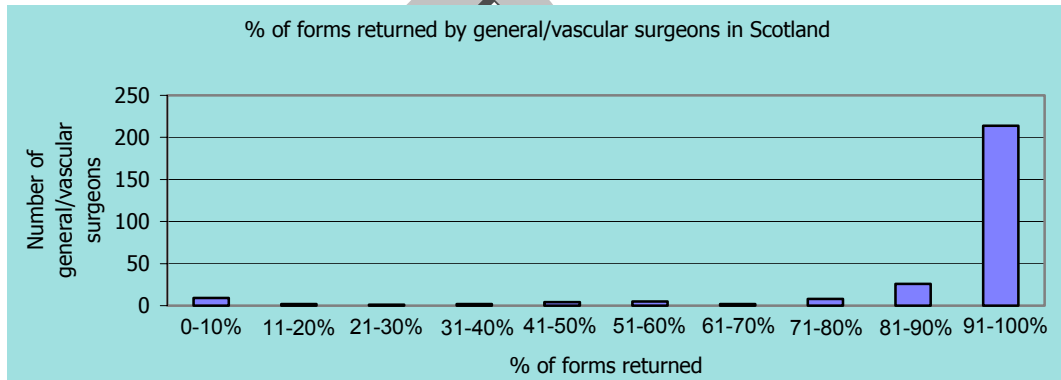
<b>Section 1</b>	Figure 1	National compliance with SASM (general/vascular surgeons)
	Figure 2	Time taken to submit your SASM surgical forms
	Figure 3	Summary of your deaths during 2003
	Table 1	National and Health Board medians and ranges for deaths/returns/ACONs per surgeon
	Table 2	Specific classifications of ACONs
	Table 3	Surgical ACONs
	Table 4	Anaesthetic ACONs
	Figure 4	Surgical assessors' views
	Figure 5	ASA grades at 1 <sup>st</sup> operation
	Table 5	ASA grade 1 and 2 patients
	Table 6	Elective and emergency surgical admissions
	Table 7	Operative and non-operative deaths
	Table 8	Post-operative deaths by type of admission
	Table 9	Consultant surgical presence at general/vascular operations
Table 10	Consultant anaesthetic presence at general/vascular operations	
<b>Section 2</b>		Details of patients who died under your care during 2003
<b>Section 3</b>	Table 11	eSCRIPS information on your patients – overall summary
	Table 12	eSCRIPS information on your patients – readmissions
	Table 13	eSCRIPS information on your patients – diagnoses
	Table 14	eSCRIPS information on your patients – procedures

## Background

This personal and confidential report has been compiled mainly from the information submitted by you and other surgeons to SASM to describe the pathway to death of patients who have died under the care of a surgeon. Increasingly, surgical care is a team effort and it is recognised that the surgeon is representing the health system caring for the patient. The following data are based on deaths reported to SASM during 2003 and identified as general or vascular surgery only.

**Figure 1 National compliance with SASM (general/vascular surgeons)**

Each bar shows the number of general/vascular surgeons returning a block percentage of forms.

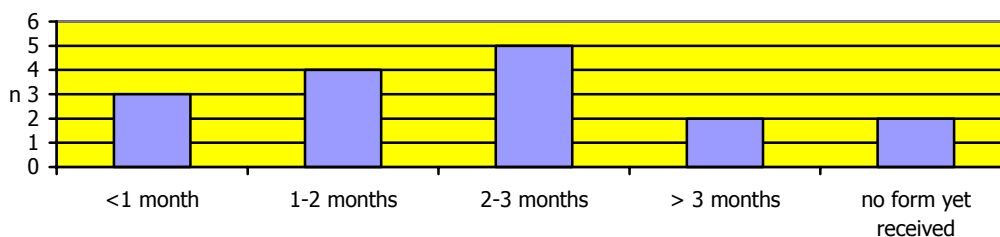


Forms which are not returned may represent a significant gap in the data and therefore may reduce the reliability of the dataset.

The General Medical Council's 'Good Medical Practice' (3<sup>rd</sup> Edition 2001) contains specific reference to compliance with Confidential Audits in paragraph 12<sup>1</sup>:

Figure 2 shows the time taken from the SASM office sending out your SASM form, to receipt of the completed surgical form in the SASM office. The national mean time for submission of SASM forms by general/vascular surgeons is 59 days.

**Figure 2: Time taken to submit your SASM surgical forms**



### <sup>1</sup> Maintaining your performance

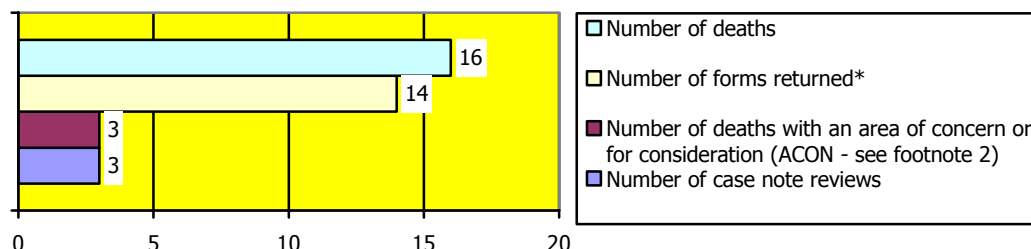
12. You must work with colleagues to monitor and maintain the quality of the care you provide and maintain a high awareness of patient safety. In particular, you must:

- take part in regular and systematic medical and clinical audit, recording data honestly. Where necessary you must respond to the results of audit to improve your practice, for example by undertaking further training;
  - respond constructively to the outcome of reviews, assessments or appraisals of your performance;
- take part in confidential enquiries and adverse event recognition and reporting to help reduce risk to patients;

## Section 1

Sixteen deaths were recorded by SASM where you were named as the consultant surgeon in charge. You returned 14 (88%) of the forms pertaining to these deaths. After figure 3, for ease of description, these deaths are referred to as "your patients".

**Figure 3 Summary of deaths in patients for whom you were the consultant in charge during 2003**



\* Details of non-returned forms are contained in section 2

Table 1 displays the median and range of numbers of:

- deaths reported to SASM per consultant general/vascular surgeon in your Health Board and in Scotland
- return of SASM forms per consultant general/vascular surgeon in your Health Board and in Scotland
- deaths with areas of concern or for consideration (ACONs<sup>2</sup>) per consultant general/vascular surgeon in your Health Board and in Scotland

**Table 1: National and Health Board medians and ranges for deaths/returns/ACONs per surgeon**

	Your Health Board	Scotland
	Median (Range)	Median (Range)
Deaths	15 (1 – 22)	11 (1 – 36)
Returns	14 (1 – 22)	9 (0 – 31)
Deaths with ACONs <sup>2</sup>	1 (0 – 7)	0 (0 – 7)

In deriving the median and range of deaths per consultant, the calculation excludes any general or vascular surgeon who had NO deaths during 2003 (n=42).

ACONs<sup>2</sup> are further classified into clinical (individual, team and other), resource and other. The proportion of ACONs<sup>2</sup> in each of these categories is shown in table 2:

**Table 2: Specific classifications of ACONs<sup>2</sup>**

Classification of ACON <sup>2</sup>	Your patients n	General/Vascular surgery in your Health Board n	General/Vascular surgery in Scotland n (%)
Clinical individual ( <i>audited consultant</i> )	2	5	82 (22%)
Clinical team ( <i>audited consultant team</i> )	2	13	106 (28%)
Clinical other ( <i>other clinical team – either within the same institution or another site</i> )		12	103 (27%)
Resource	0	1	16 (4%)
Other ( <i>ACONs outside the above</i> )	1	4	72 (19%)
TOTAL	5	35	379 (100%)

<sup>2</sup>ACONs are areas of concern or for consideration which are identified by the surgical or anaesthetic assessors (either first line or case note reviewers). An area of concern is where the assessor believes that areas of care should have been better. An area for consideration is where the assessor wishes to draw the clinician's attention to areas of care that he/she believes could have been improved, but recognises that it may be an area of debate. These ACONs are coded before being entered on the database.

A maximum of three ACONs can be ascribed to each death by the surgical assessors and a maximum of three ACONs can be ascribed to each death by the anaesthetic assessors.

## Section 1

**Table 3: Surgical ACONs**

Three of your patients had 5 surgical ACONs. The number of these ACONs for consultants in the same speciality within your Health Board area and in Scotland is also shown in table 3.

Description	ACON classification	Your patients	SASM Study Nos. (Case details are in section 2 of this report )	General/ Vascular surgeons in your Health Board (n=21)	General/ Vascular surgeons in Scotland (n=253)
Operation should not have been done or was unnecessary	Clinical individual	1	XXX	2	22
Post-operative bleeding after open surgery	Clinical individual	1	XXX	1	6
Delay in transfer to surgical unit	Other	1	XXX	1	6
Delay to surgery ie earlier operation desirable	Clinical other	1	XXX	9	23
Delay in transferring patient to ITU	Clinical team	1	XXX	3	19

**Table 4: Anaesthetic ACONs**

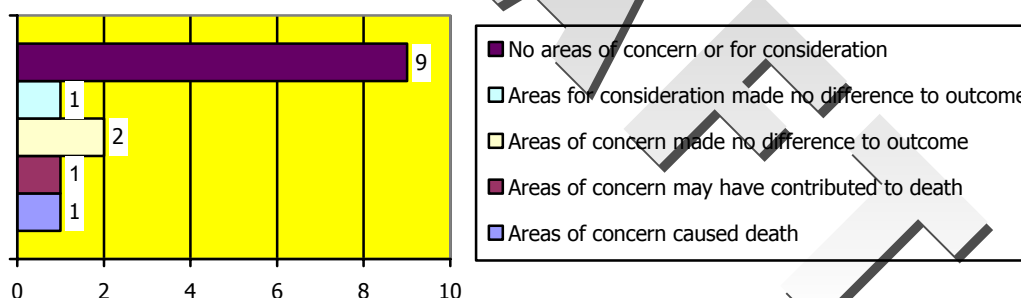
Two of your patients had 2 anaesthetic ACONs. The number of these ACONs for consultants in the same speciality within your Health Board area and in Scotland is also shown in table 4.

Description	ACON classification	Your patients	SASM Study Nos. (Case details are in section 2 of this report )	General/ Vascular surgeons in your Health Board (n=21)	General/ Vascular surgeons in Scotland (n=253)
Delay in seeking anaesthetic advice	Clinical team	1	XXX	2	3
Anaesthetist too junior	Clinical team	1	XXX	3	10

**Figure 4: Surgical assessors' views**

Surgical assessors are asked to select the most appropriate statement from a choice of five, to describe the management of each patient. The number of your deaths classified by statement is shown in figure 4.

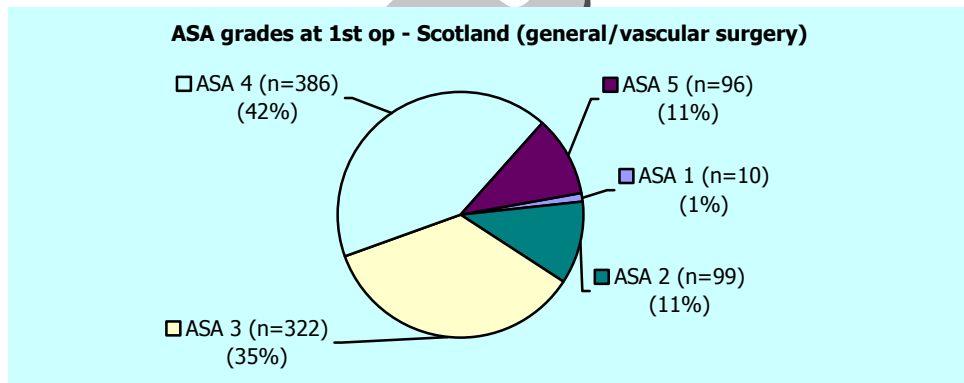
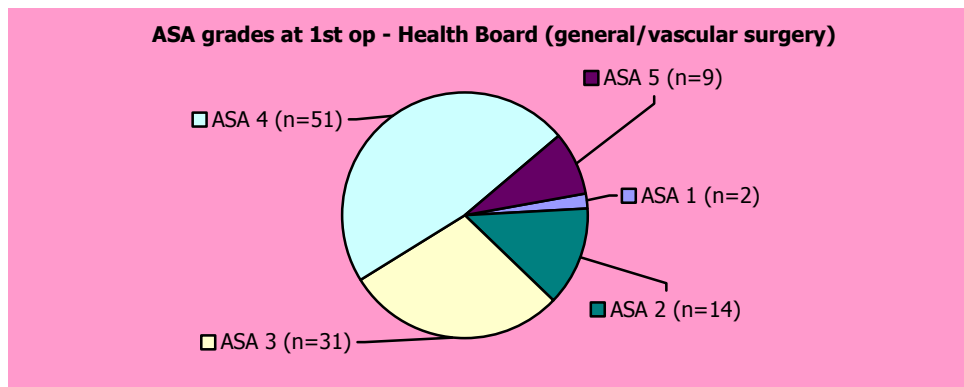
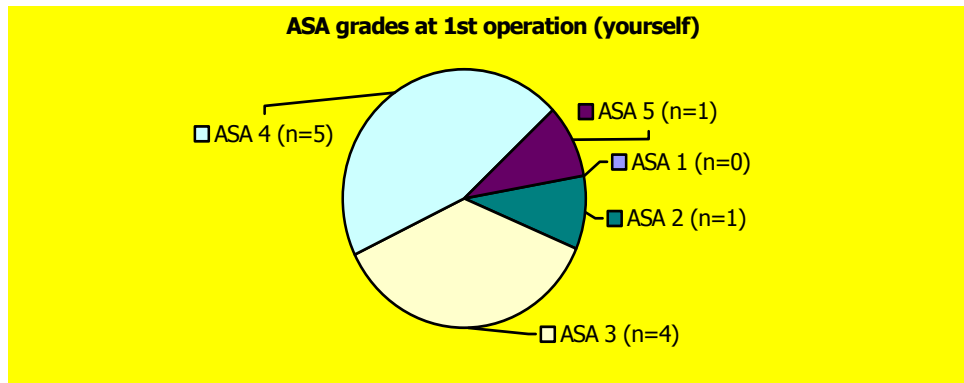
Assessors' statements about management of patients



## Section 1

Eleven of your patients underwent operative procedure/s before death. Seven had one operation and 4 had 2 operations. The ASA grades at 1<sup>st</sup> operation are shown in Figure 5:

**Figure 5: ASA Grades at first operation recorded by SASM**



**Table 5: ASA grade 1 and 2 patients**

Table 5 shows any of your patients who were ASA grades 1-2 and who subsequently died:

ASA Grade	SASM Study number(s) (Case details are contained in section 2 of this report )
1	XXX
2	XXX

## Section 1

**Table 6: Elective and emergency surgical admissions**

Table 6 shows the number of elective and emergency surgical admissions who died during 2003.

Type of admission	Your patients n	General/vascular surgery in your Health Board	General/vascular surgery in Scotland n (%)
Elective	*1	20	416 (14%)
Emergency	15	228	2570 (86%)

\* SASM study number xxx. Case details are contained in section 2 of this report.

Table 7 shows the number of patients who died post-operatively and the number who died without having undergone an operation or procedure during their last admission or within 30 days of death.

**Table 7: Operative and non-operative deaths**

Operative or non-operative death	Your patients n	General/vascular surgery in your Health Board n	General/vascular surgery in Scotland n (%)
Operative	9	125	1202 (40%)
Non-operative	2	150	1818 (60%)

**Table 8: Post-operative deaths by type of admission**

Type of admission (post-operative deaths)	Your patients n	General/vascular surgery in your Health Board n	General/vascular surgery in Scotland n (% of operative deaths)
Elective	1	11	214 (18%)
Emergency	2	114	988 (82%)

Tables 9 and 10 show the number of post-operative deaths in general/vascular surgery where a consultant surgeon (either operating or assisting) or a consultant anaesthetist was present in theatre at the 1<sup>st</sup> operation recorded on the SASM form. These deaths are further split into elective and emergency admissions.

**Table 9: Consultant surgical presence at general/vascular operations**

Post-operative deaths with consultant surgeon present at operation	Your patients n	General/vascular surgery in your Health Board n	General/vascular surgery in Scotland n (% of elective/emergency admissions who died)
Elective admission	1	9	196 (92%)
Emergency admission	7	87	757 (77%)

**Table 10: Consultant anaesthetic presence at general/vascular operations**

Post-operative deaths with consultant anaesthetist present at operation	Your patients n	General/vascular surgery in your Health Board n	General/vascular surgery in Scotland n (% of elective/emergency admissions who died)
Elective admission	1	11	211 (99%)
Emergency admission	5	97	786 (80%)

## Section 2

### Details of patients who died under your care during 2003\*:

#### *\*Case allocation*

Staff in the SASM offices contact each hospital mortuary to obtain lists of patients who died on surgical wards and in Intensive Care Units. Where the lists do not contain the name of the consultant surgeon in charge of the case, then SASM staff contact the wards or the medical records offices to secure this information. If the consultant in receipt of the form informs a SASM office that a different consultant was in charge of the case, then the database is altered accordingly.

A) Details of cases where no form was received by SASM:

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

B) Full details are given for patients who had an ACON, or who died following an elective admission, or who were ASA grades 1 or 2 or who had a case note review. For all other patients, only minimal demographic data are given.

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

## Section 2

Study Number	x
Name	x
Date of birth	x
Hospital Number	x
Type of admission	
Date of admission	x
Date of 1 <sup>st</sup> operation	x
Date of death	27/02/2002
Diagnosis	Other peripheral vascular disease
ASA grade	x
1 <sup>st</sup> operation	Other bypass of femoral artery or popliteal artery NOS
2 <sup>nd</sup> operation	Exploratory laparotomy
Surgical ACONs	Operation should not have been done or was unnecessary
Anaesthetic ACONs	n/a
Case note review	Yes (See below)

### **Elderly patient (80 year old) with wide spread arterial disease, CVA and past history of rectal cancer subjected to negative laparotomy**

An 80 year old patient with critical right lower limb ischaemia admitted for infra inguinal bypass. On admission MRSA and septicaemia was diagnosed and surgery postponed. During which time, the left limb began to deteriorate and he developed critical ischaemia on this side, including pre-gangrenous changes of the left great toe. His septicaemia was treated during the course of which a CT scan was obtained and this demonstrated a splenic infarct.

Six months previously, this patient had undergone a low Hartmann's resection of a Duke's B rectal cancer. There had been no sign of any recurrence.

A left femoral popliteal bypass was performed using reverse saphenous vein, because of the deteriorating picture in the left leg 5 months later and one week following the bypass graft the left great toe was amputated. The right side continued to show signs of critical ischaemia including a deep ulcer on the dorsum of the foot. During the next 2 weeks numerous entries in the case sheet refer to continuing infection as a problem in the management of this patient and specifically colonisation of the thigh wound and toe amputation site with pseudomonas. Mention is made of the continuing deep ulceration on the right foot, treatment of which was impossible because of the continuing infection elsewhere. During this period a haematoma was evacuated from the thigh wound under local anaesthetic. The condition further deteriorated and the note mentions the fact he was tachycardic and unwell. Gentamicin was commenced and the possibility of starting antifungal treatment was raised. He was noted at this point to have reduced power in his right hand and a right facial weakness. CT confirmed the presence of the left CVA. A note was made that the resuscitation status should be discussed with the relatives.

Three days later, he was noted to have severe lower abdominal pain and atrial fibrillation. He was seen by another surgeon, who queried ischaemic bowel and arranged mesenteric

## Section 2

angiography. There was no occlusion demonstrated on the angiogram films, but the case note read "needs emergency laparotomy". This was carried out, the only finding of note being a distended bladder. Over the ensuing two weeks he deteriorated with worsening septicaemia and cardiac failure.

### Comment

From the technical vascular point of view I would make no criticism of the management. However, although there was an entry in the case note to the effect that resuscitation status was going to be discussed with relatives, there does not appear to have been a clear plan formulated following this.

He was seen by another surgical team and subjected to a laparotomy, on what I would regard as flimsy evidence of an ischaemic bowel, but even if a diagnosis of ischaemic bowel had been confirmed, it is difficult to foresee what benefit a laparotomy would achieve in an 80 year old patient already septic, fibrillating and in cardiac failure with an established CVA and in whom the vascular surgical team had indicated they were discussing the resuscitation status with the relatives.

Under these circumstances I would be critical of this decision to go ahead with a laparotomy.

### **LETTER OF REPLY FROM CONSULTANT SURGEON**

Thank you for returning a case note assessment on the above case. I would wish to enter a reply to some of these comments and for these to be submitted at the end of the casenote review.

The vast majority of the care of this patient up until the day of death had been mine. The decision to perform a laparotomy was made by another consultant surgeon. I was called in when not on call, in order that the surgeon who was on call, who had made the decision, could embark upon a ruptured aortic aneurysm repair. I was, therefore, presented with a case literally going to theatre and either stopping the process, countermanding another consultant's decision and completely reassessing, which if the other consultant had been correct, would have probably pushed the patient well passed any hope of salvage, or proceeding. Unfortunately, I found this an incredibly difficult situation and must admit to being unsure of the diagnosis. I did, however, bow to the other consultant involved in this case, who had been observing the patient over a number of hours and had made a decision based on that observation. I, therefore, felt very reticent to countermand another surgeon's opinion on the basis of a single acute review. In hindsight, this was the wrong decision.

Study Number	x
Name	x
Date of birth	x
Hospital Number	x
Date of admission	x
Type of admission	

## Section 2

Date of 1 <sup>st</sup> operation	x
Date of death	14/04/2002
Diagnosis	Blood vessel graft with complication, without blame
ASA grade	
1 <sup>st</sup> operation	Revision of reconstruction involving aorta
2 <sup>nd</sup> operation	Exploratory laparotomy
Surgical ACONs	n/a
Anaesthetic ACONs	n/a
Case note review	Yes (not yet received)

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

Study Number	x
Name	x
Date of birth	x
Hospital Number	x
Date of admission	x
Type of admission	
Date of 1 <sup>st</sup> operation	x
Date of death	03/05/2002
Diagnosis	Abdominal aortic aneurysm which has ruptured
ASA grade	x
1 <sup>st</sup> operation	Emergency replacement of aneurysmal segment of aorta
2 <sup>nd</sup> operation	Exploratory laparotomy
Surgical ACONs	Post-operative bleeding after open surgery
Anaesthetic ACONs	n/a
Case note review	No

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

Study Number	x
Name	x

## Section 2

Date of birth	x
Hospital Number	x

Study Number	x
Name	x
Date of birth	x
Hospital Number	x
Date of admission	x
Type of admission	
Date of 1 <sup>st</sup> operation	x
Date of death	26/08/2002
Diagnosis	[D]Widespread diabetic foot gangrene
ASA grade	x
1 <sup>st</sup> operation	Amputation of foot NOS
2 <sup>nd</sup> operation	n/a
Surgical ACONs	Delay in transfer to surgical unit Delay to surgery ie earlier operation desirable Delay in transferring patient to ITU
Anaesthetic ACONs	n/a
Case note review	Yes (see below)

### **A case of osteomyelitis leading to generalised sepsis in a young diabetic.**

This man was admitted to the medical ward in the afternoon with a 48 hour history of vomiting and diarrhoea. It had been noted that his right foot was hot, red and swollen. He had also had a lower respiratory tract infection 2 weeks previously.

There was a history of chronic poor health; insulin dependant diabetes, Addison's disease, asthma, cigarette smoking, pulmonary emboli, congestive cardiac failure, pancreatitis and loss of sight in the right eye. He had had the left lower leg amputated 2 years previously. The nursing notes, however, document that he was fully self caring. His medications included Insulin, hydrocortisone, lisinopril, nifedipine, digoxin, frusemide, acetazolamide, amitriptyline, salbutamol, sodium valproate and arthrotec. On examination there was obvious anaerobic infection of the right foot with cellulitis in the lower leg. He was afebrile and cardiovascularly stable. Blood results revealed low Hb of 8.3, WCC 28,4 and elevated urea; 19.3 and creatinine 308. It was noted that creatinine 4 months previously had been 120. Blood glucose was 20.2.

Initial management consisted of Flucloxacillin, clindamycin, insulin sliding scale, IV fluids and request for vascular surgery review. The vascular surgery SpR saw him at 0200 and noted that he had previously been mobile with his left artificial leg. He recommended adding metronidazole and performing an angiogram if he remained stable.

## Section 2

The next day he was transferred to the surgical ward. He had blood gases, which noted  $P_{O_2}$  8.9 on 5 litres of oxygen although his breathing was comfortable. There were basal crepitations in both lungs. He was taken to theatre at 2100 for guillotine amputation of the foot under regional anaesthesia. Both anaesthetist and surgeon were SpRs and the operation took 1 hour with 500 ml blood loss estimated. As there was only one IV cannula in situ for PCA, insulin and fluids, planned post operative transfusion of two units of packed cells, antibiotics and hydrocortisone were not given. Multiple attempts at venous access by surgical staff and the anaesthetist were unsuccessful. Central venous access was not sought because of infection and inability to tolerate head down position! By lunch time the next day he was noted to have been breathless all day and the charts show rising respiratory rate and heart rate together with falling blood pressure

The next record is at 1800, when he was seen for respiratory distress.  $SpO_2$  was 40% breathing air and his respiratory rate was 48bpm. Blood gases had deteriorated; pH 7.29,  $pCO_2$  5.94,  $pO_2$  4.34,  $HCO_3^-$  21 on 7 litres oxygen. CXR showed infiltration suggestive of pulmonary oedema or ARDS. He was managed with 100% oxygen, nebulisers, aminophylline and frusemide 50mg IV and reviewed by the surgical SHO. His deterioration continued, but ITU was not considered until medical registrar review. His entry in the notes is not timed, but was probably around 2200. The ITU SpR saw him at 2245. He noted that the patient was moribund, but felt that he had insufficient functional reserve to benefit from intensive care. He discussed this with his relatives, the consultant anaesthetist and vascular surgeon who agreed.

Following this he was noted to have had a fall in Hb to 7.7g/dl. Urea and electrolytes had slightly improved and he passed good volumes of urine. Unfortunately, he remained severely hypoxic and in respiratory distress until he died at 0300.

### Comments:

There seems to have been some delay in operation because of initial admission to the medical ward. Postoperative care seems to have been compromised by the difficulty in venous access and delay in recognising his deteriorating respiratory function. He would probably have benefited from central venous access, to allow transfusion and to differentiate pulmonary oedema from ARDS. He had respiratory failure and might have benefited from earlier transfer to Intensive Care. The presence of reversible factors, especially anaemia and resolving acute renal failure might have mitigated the judgement that his chronic health was too poor to allow him this chance.

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

## Section 2

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

Study Number	x
Name	x
Date of birth	x
Hospital Number	x

DRAFT

## Section 3

### eSCRIPS data (courtesy of ISD)

The following tables are presented from the eSCRIPS (Scottish Consultants Review of Inpatient Statistics) web-based package available to all NHS consultants in Scotland. They are intended to provide an indication of the volume of your inpatient and daycase caseload by diagnostic and procedure group, providing some background to the deaths registered through SASM. Other detailed statistics on the web from eSCRIPS include details of; how many of these episodes were emergency admissions; how many were planned; the number of re-admissions; and the number of deaths.

eSCRIPS information comes from routinely collected data on hospital inpatient and daycase episodes of care (SMR01 records). These data are derived from hospital PAS systems and medical records coding from case notes & discharge summaries. A patient's stay in an NHSScotland hospital from admission to discharge home or death is made up of one or more 'episodes of care'. During a continuous stay in hospital, a patient may generate several episodes on SMR01; for example, due to a change of speciality, a change of consultant for medical reasons or a change in location. In eSCRIPS each episode is shown separately so a single patient stay may be counted more than once in the statistics presented.

**Table 11 Overall summary by specialty 2003**

Individual consultant - Overall summary 2003					
Specialty	Inpatient episodes	Mean Length of Episode (days)	Daycases	Daycase rate	Total
General Surgery	87	12.3	11	17.2	98

**Table 12 Readmissions to your hospital(s) 2003**

Individual consultant – Readmissions to your hospital(s) 2003							
Specialty	Hospital	Yourself			Hospital		
		% readm - 7 days	% readm - 28 days	Total Discharges	% readm - 7 days	% readm - 28 days	Total Discharges
General Surgery	Anywhere	1.7	5	60	2.5	6.9	2326

Note: Readmission rate is based on 10 months discharges

**Table 13 Total episodes by diagnosis group 2003 (Specialty General/Vascular Surgery)**

Individual consultant - Total episodes 2003						
Diagnosis Groups	Yourself		NHS Board		Scotland	
	Number	%	Number	%	Number	%
Peripheral vascular disease	50	51	214	3.5	3350	4
Varicose veins	17	17.3	217	3.5	1813	2.2
Symptoms & signs	7	7.1	223	3.6	3088	3.7
<b>Total</b>	<b>98</b>		<b>6142</b>		<b>83986</b>	

Note: only diagnostic groups with more than 5 patients are shown

**Table 14 Total episodes by procedure group 2003 (Specialty General/Vascular Surgery)**

Individual consultant - Total episodes 2003						
Procedure Groups	Yourself		NHS Board		Scotland	
	Number	%	Number	%	Number	%
No operation	20	20.4	1372	22.3	21817	26
Varicose vein operations	18	18.4	220	3.6	1754	2.1
Diagnostic transluminal operations	16	16.3	76	1.2	797	0.9
Open operations on branches of aorta	8	8.2	28	0.5	185	0.2
Open operations on iliac, femoral artery etc	8	8.2	31	0.5	479	0.6
Amputation - leg	7	7.1	25	0.4	264	0.3
Open operations on aorta	6	6.1	12	0.2	254	0.3
Transluminal operations on iliac, femoral artery etc	6	6.1	25	0.4	385	0.5
<b>Total</b>	<b>98</b>		<b>6142</b>		<b>83986</b>	

Note: only procedural groups with more than 5 patients are shown