

Dr. Colin Pritchard, Research Professor, Psychiatric Social Work, School of Health & Social Care, John Brackstone, School of Management Services, Bournemouth University, and, Dr. John MacFie, Professor of Surgery, University of Hull

**Patient Safety -the Voice of 549
Surgeons: Adverse Events &
Improving Patient Safety**

**Informal Background:“ An Incredible Journey: Royal Colleague of Surgeons
`Consultant Re-certification sub-committee’ (Research Outcomes & Peer
Reviews). A self-evident location for Psychiatric Social Work?”**

- **Voice of the Surgeon: Adverse Events & Improving Patient Safety in Theatre**
- **Intro: CMO high profile concern about `Safer Surgery’ (2008)- Self-evidentially Crucial, Laudable & Necessary but should be Evidence Based.**
- **We found most research papers focused negatively upon the Surgeon.**
- **(Quoted in a Working paper in RCS Re-validation committee) “If I was a Consultant Surgeon, I’d feel like Henry V- *“What all upon the King!... We must bear all... subject to the breath of every fool?”*.**
- **We Recognised Need to Ask Surgeons *Their* views and experience of Adverse Events; What Impairs Patient Safety in Theatre & How to Improve matters? This is our report on *‘The Voice of 549 Surgeons’***

Methodology & Minor Findings

Pritchard C, Brackstone J & MacFie J (2010) Adverse event and patient safety in the operating theatre: Perspectives of 549 surgeons. *Annals of Royal College of Surgeons* (Supplement) 92, 1-4

- **1] Surveyed ASGBI members in non-attributable, confidential on-line questionnaire.**
- **2] Structured research-based statements (e.g. check lists, pre-op briefing etc); Incidence of Near Misses (NM) & Adverse Events in (AE) last 2 weeks, juxtaposed with number of estimated operations to calculate rate of Adverse Events every 2/52.**
- **3] Open-ended Questions to 'Hear Voice of Surgeon' - a. What Impairs Patient Safety? b. What is Best / Worst About being a Surgeon? c. What do You recommend to Improve Patient Safety?**
- **549 Responded (24% response), majority of responses received out of office hours; consisting of 69% general surgeons; 78% Consultants, very Experienced 65% >20years.**
- **Problems: 'Daily Mail' Headlines 40% reported NM & 19% reported AE last 2weeks!!**

Adverse Event (n=104) v Non-Adverse Event (n=445) Respondents

- Based upon 4 or 6 average sessions p.week = 12,920 to 19,380 operations.
- NM ranged 1.62% to 2.4%; Minor AE 0.54% to 0.8% BUT if its You its 100%!
- Serious AE 0.22% to 0.33%, thus all AE 0.76% to 1.13% of all operations.
- How Does this Compare, is this a `Good/Bad` result?
- NPSA (2007) 129k `Untoward Incidents` based on CMO data= 1.6% ops.
- Results indicate ASGBI respondents open, honest, reliable & more valid.
- N.America: de Vries et al (2008) Systematic review covering 74,485 patients- had 9.2% AE & 7.4% ending fatally = 0.68% of all cases.
- If 10% of all our Serious AE's (0.33%) ended fatally = 0.033%.
- Estimated: England & Wales AE Peri-op mortality (POM). Based on CMO & projecting on Scottish Surgical Audit POM linked to possible AE yields 0.035% of all operations.
- If its You or Mine it's 100% but surely Better than expected?

Flavour of Structured Responses to 30 Research Based Statements
Impairing Safety AE (n=104) v Non-AE (n=445) answers
(Chi square tests between AE v Non-AE groups 1 d/f p value)

Statement	Often & Very Often:		AE	v	Non-AE	%
<i>Erosion Surgeon's ability to influence theatre/bed management.</i>	73	v	56		<0.006	
<i>Target & adding numbers Ops as if each case had same weighting</i>	42	v	37		n.sig	
<i>Work force inadequate to respond appropriately to demands of list.</i>	48	v	35		<0.02	
<i>Not Routinely working with same Theatre Team</i>	45	v	34		<0.07t	
<i>Managers place too much pressure achieve extra numbers of cases</i>	41	v	34		<0.04	
<i>Insufficient Recovery Beds</i>	42	v	30		<0.05	
<i>Inadequate Documentation in Theatre</i>	44	v	30		<0.02	
<i>Poor nursing documentation post op-care</i>	43	v	28		<0.002	
<i>Challenge by managers/politicians forget paramount patient safety</i>	37	v	30		<0.08t	
<i>Untoward incidents inadequate reported or followed-up</i>	46	v	26		<0.0001	
<i>Wrong or faulty equipment</i>	35	v	19		<0.001	
<i>Waiting list initiatives equals surgeons wouldn't have listed that pnt</i>	38	v	26		<0.06t	
<i>Staff not considering wide demands of list prior to operating</i>	28	v	22		<0.02	
<i>Poor Team work</i>	21	v	14		<0.07t	
<i>Failure to do `pre-flight' checks</i>	12	v	13		n.sig	

Flavour of Open-Ended Answers

- **Best & Worst About Being Surgeon:** Predominately patient Outcome focused- moving to read-highly vocationally orientated.
- **What Impairs Safety?:** Surgeon has full clinical responsibility but Not in full clinical control; managers ignore case mix; pooled lists (21% operating on pnts not seen before); faulty equipment; inadequate workforce; inconsistency in theatre teams; inherent tension twixt management & surgeons perspectives; not with same anaesthetists.
- *“Don’t be seduced by your manager into making do & thinking you’re being heroic, you’re not, you’re just being dangerous”* Quoted by Consultant of 30 years.
- **How to Improve?** End pooled lists, continuity in surgical teams, better equipment, reduce tension twixt managers & surgeons (as well as `obvious’ research findings, check lists, pre & post op briefing etc, etc).
- **Conclusion:** Hearing the Voice of the surgeon Highlights the *Operational Context in which surgeons practice*. Hence no more “All upon the King... subject to the breath of every fool”
- So far all about `Outcome/ Output’, what about INPUT? Mrs T. said “You can only have the services you can afford” [RIGHT] but UK Doesn’t afford as much as others?