



Chief Health Officer Seminar Series

Seminar 3 – Thursday 15 July 2004

Audit and Quality Practice Issues – The Reality in a Surgeon's Life

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Quality management in any human activity depends on knowing what is actually being produced, what it costs, how reliable and how acceptable (and therefore saleable) it is. In our case this translates to safety and quality in clinical care. We cannot understand our performance in the provision of surgical healthcare without reliable, relevant data. Information does not just appear for us when needed. When information does appear, it is quite likely to be unwelcome unless we have set its production in motion and carefully maintained the processes leading to its analysis and dissemination. Events leading to and surrounding well-publicised major system failures such as Bristol paediatric surgery, King Edward gynaecological surgery, and Canberra Hospital neurosurgery attest to this.

The most useful information is collected as a process runs, is cumulative and is analysed regularly including referencing against external and internal standards. It is available to support processes in quality and safety, risk management, performance management, resource planning and education.

The ACT hospitals have many committees and processes for quality, safety and clinical review. However, there is a profound lack of reliable data. There are pockets of data collection but no consistency in methods, programs or analysis. There is very little in the way of resources or direct support for surgical audit activities in ACT public hospitals.

The technical resources needed are not major and are readily available.

The methodologies are well established.

We have the skills in data collection, management and analysis.

The need is obvious, yet we do not do it.

Doctors Dugdale and Sherbon have previously spoken of our moves to a less competitive, more collegiate style of management designed to foster sharing of aims, processes and responsibilities and under which and accountability will be distributed.

Dr Faunce has written about whistle blowing, major system failures, and recommendations from the inquiries they led to. He will talk to us about technology available to monitor performance.

I will explain what is currently happening in surgical audit in the ACT. I will speak to the need for greater organisational leadership and commitment required to create a culture of performance insight in surgical services in ACT public hospitals and the need for an ACT wide audit of surgical activity, morbidity and mortality.

I will ask how any of us, from the minister and CEO down can fail to address surgical audit as an urgent priority.