ALL PARTY PARLIAMENTARY GROUP ON PATIENT SAFETY

Safer Surgery – Are risks being minimised for Patient Safety? – 10th June 2008

Overview:

The focus of this meeting of the All-Party Parliamentary Group on Patient Safety was to discuss what advances are being made in ensuring that the risks of surgery are being minimised for patients. There have been many innovative developments in the world of surgery in recent years, which have brought huge advances to modern surgical techniques, and are now less invasive such as laser eye surgery and key-hole surgery. However, surgery still poses significant risks to patients – from the possibility of infection, damage to other organs and wrong-sided procedures.

Speakers:

- Dr Clare Lemer, Clinical Advisor to the Chief Medical Officer, Department of Health
- Judy Birch, Leader of The Pelvic Pain Support Network and Patient Advocate
- Christopher Chilton, Council Lead for Patient Safety, Royal College of Surgeons

Welcome:

Dr Howard Stoate MP, Chair of the group, welcomed all attendees to the meeting and opened with a brief introduction of the speakers and the issues at hand. Dr Stoate noted that surgery always poses an element of risk, but stressed the importance of minimising these risks wherever possible.

Dr Clare Lemer:

Clare Lemer, Clinical Advisor to the Chief Medical Officer at the Department of Health started by citing the case of a man suffering from lung disease who had the healthy, rather than the diseased section of his lung removed during surgery and died shortly afterwards. Dr Lemer said that three years ago, your risk of dying during surgery from the adverse effects related to anaesthesia was 1 in 5,000. Now, it is 1 in 3,000. She claimed safety during surgery is getting better, but needs improvement.

She explained that the Department of Health is joining the World Health Organisation's Second Global Patient Challenge, a movement established in January 2007 which endeavours to establish global safety checklist guidelines that surgeons, nurses, and others involved in surgery can adhere to in order to make surgery safer. The challenge involves three key stages at which simple safety checks (such as: Has the right spot been marked? Is everything clean? Do we have the right equipment?) should be carried out.

Judy Birch

Judy Birch, Leader of The Pelvic Pain Support Network spoke about her own personal experience of surgery, which had failed to ensure the safety of the patient. Ms Birch has suffered from severe pelvic pain since the age of 17, which started from cyclical and developed into acute pain. During her treatment, she has seen experts

from the UK, the USA, Belgium and France, and she discussed the differing ways she was treated in those countries. She noted the importance of offering a patient pain relief after an operation, and of discussing their level of pain with them.

Ms Birch said that the Pelvic Pain Support Network hoped gynaecologists and surgeons would work as interdisciplinary teams when it comes to adhesions. They recommend surgeons share personal outcomes and surgery reports with patients. She added that patients should be encouraged to ask questions about their surgery.

At this point, Dr Stoate left briefly to attend a vote in the House of Commons, and the APPG was chaired by Baroness Masham of Ilton. A discussion was held in his absence, on the topics of whether safety checklists were compatible with different specialities, and the complaints procedure for unsatisfactory surgery.

Christopher Chilton

Christopher Chilton, Council Lead for Patient Safety at the Royal College of Surgeons started by encouraging more patient safety training, both with curious undergraduate medical students, and postgraduate students learning about the practicalities of the hospital as a workplace. He stressed the importance of following up with a patient in the ward or at home after an operation, as outcomes can be uncertain.

Mr Chilton said that doctors should be role models, and that it is a surgeon's duty to lead his team in ensuring patient safety. He discussed the benefit a quiet, and fully prepared environment can have on the safety of surgery, along with the benefits of technology, which can make surgery faster and less painful; but can be expensive and difficult to learn to use as well.

Mr Chilton called on the Royal College of Surgeons to establish a patient safety board, but praised their £13m 'Eagle' project to improve teaching and training. Lastly, he reminded the audience that a surgeon is not a technician, but a physician who operates.

Conclusion:

Dr. Stoate thanked each speaker and invited attendees to ask any questions they might have. The panel answered on a variety of subjects, including what PCTs could do to help with pain management, whether following up with a patient can impact on changing practice, and how hierarchy in the operating theatre is taken into consideration during the complaints procedure. On this subject, Mr Chilton believed strongly that a leader was needed within the team to take responsibility for the actions within the surgery; but said that there needed to be a good peer review system in place, with accuracy and confidentiality taken into account.