

The Minutes of the meeting of the Derby Medical Society

Held on 9th December 2014 in the Derby Medical School

Apologies: none received

Welcome: Mr S Iftikhar, President

Minutes for the meeting 25th November 2014: Read by Mr S Milner, Junior Secretary, and approved.

Guest Lecture: Mr Asif Hasan, Consultant Paediatric Cardiac Surgeon, Freeman Hospital, Newcastle.
“Did we learn any lesson from Bristol debacle?”

Mr Hasan described the ‘Bristol Heart Scandal’, which came to public attention in 1998 with tabloid headlines such as “Doctors of Death” (Daily Mirror), as well as “Dealing with Problem Doctors” (BMJ). 29/42 paediatric patients undergoing arterial switch operations had died postoperatively, and the Bristol Heart Enquiry came about because of a newly-appointed anaesthetist whistleblowing. The enquiry ran from 1998-2001, heard evidence from 577 witnesses, cost £26m, and made 198 recommendations. These included the need for:

- Regular medical appraisal
- Regular revalidation
- National outcomes monitoring
- Minimum surgeon and unit case volumes

As a result, the Central Cardiac Audit Database (CCAD) was set up. This now records mortality data for 35 different operations, and publishes funnel plots showing different cardiac surgery units.

An investigation in 2010 in Oxford, when a series of postoperative deaths was highlighted by a new surgeon, found that mortality data were being hidden by putting patients into a ‘miscellaneous’ group that was not subjected to data analysis. However, the introduction of monitoring has been paralleled by decreasing postoperative mortality. 444 arterial switch operations performed 2007 – 2010 had a 1.3% mortality. However, routine outcomes monitoring may have unintended consequences:

- Surgeons stop operating or move abroad – eg to USA or Australia where salaries are much higher
- Complex problems are referred to other units or refused surgery
- Surgeons may offer less risky options to patients.

The problems are what to monitor, how to stratify risk, and how to prevent ‘gaming’.

Bristol recommendation 195 suggested minimum case volumes for individual surgeons of at least 40 – 50 cases per year. A service review of paediatric cardiac services in 2003 recommended a minimum case volume of at least 300 cases per unit per year. This would mean reducing the number of UK centres from 11 to 7 units, which is politically impossible. Such reconfiguration, suggested again by a report in 2010, was subjected to legal challenge, was over-ruled by the Health Secretary, and never went ahead.

Mr Hasan concluded by offering some lessons learned:

- That political expediency always trumps clinical needs
- That service reconfiguration can lead to unintended consequences
- That whistleblowing usually comes with personal and professional costs
- That despite massive expenditure on enquiries and reports, there is still nobody who is accountable for paediatric cardiac surgery services

Questions included:

- Whether we should be optimistic or pessimistic about the future
- Who has ultimate power to make reconfiguration decisions
- Whether surgeons should do just the operating and leave decisions about referral for surgery and peri-operative management to cardiologists
- Learning about how teams function
- Common causes of mortality
- Implications for training
- The overseas picture for cardiac surgery
- The effect of individual surgeon case volume

Vote of thanks: given by Mr Ken Callum

Register: signed by 28 members, 1 trainee, 3 students and 3 guests

Next meeting: 6th January, 2015

.....
SY Iftikhar, President

Date: