Surgical audit and mortality review

In response to the contribution by McDonald *et al.* (April 1991 *JRSM*, p 213) we would recommend being more precise about the term surgical audit which encompasses three distinct activities. The first is an administrative audit: bed occupancy, management problems, day care usage etc. These are important and necessary but of minimal interest to most junior and professional staff. The second is a numbers audit: wound infections, hernial recurrences etc. These are necessary and may well benefit and improve or alter surgical practice. They are of more interest to staff and in part spill over into the third group. This is the educational audit, a case analysis which should be the centrepiece of a surgical unit's activity with mortality review its highlight.

It is this latter type that McDonald *et al.* describe. We believe that to achieve its main aim, that of a critical review, a tight format must be adhered to with clearly defined questions and answers. These must include a detailed review of the following: admission delays, history taking, physical examination, quality/interpretation of preliminary investigations, operative treatment (technique used, by whom, with what supervision), anaesthesia, postoperative care, nursing. All decision making should be critically analysed. Only then should the final pathology findings be revealed. By these means any deficiencies will be raised and appropriate lessons learnt.

These are difficult meetings to conduct; they demand open comment and criticism without blame and the participation of other relevant departments' senior staff is essential for authoritative comment. The chairmanship should rotate among the surgical consultants. Attendance of all surgical staff should be mandatory. This system formed the basis of a bimonthly meeting in a New York University teaching department headed by one of us (AEK). The main actors at each meeting never forgot the lessons learned so publicly and the role of the mortality audit was firmly enshrined as a teaching and learning exercise and not merely as a statistical one.

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He/she or hshe?

I am sorry that Ms H Thomas has taken offence to the fact that I used the term 'he' in my references to medical students (November 1991 *JRSM*, p 692) in the Symposium on the teaching of Pathology. None of my students, I am sure, would ever accuse me of being a male chauvinist. It is merely that, being a simple surgeon, I dislike the use of the clumsy 'he/she' that she proposes. Would Ms Thomas be satisfied if I invent a new word, 'hshe', to apply to both?

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I refer to the letter from H Thomas (November 1991 *JRSM*, p 692). My dictionary (Readers Digest Great Illustrated Dictionary) defines 'he' as follows: '1. used to represent the male person or other being last mentioned or implied. 2. used to represent *any person whose sex is not specified*' (my emphasis).

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Career blight following operating theatre injuries

In the context of HIV infection of theatre staff, Dr Williams (June 1991 *JRSM*, p 327) rightly suggests that the advice of the occupational health experts should be obtained. The problems of hepatitis B are similar. Considerable efforts are also being made to increase the uptake of hepatitis B vaccination. There is, however, a known failure to develop immunity in about 10% of those vaccinated. Thus, there will always be surgeons, nurses and others who will develop the illness as a result of their occupation and who may remain infectious for the rest of their working lives. Some of these colleagues are, perhaps, transferred to desk jobs but others who are unable to come to terms with the loss of their chosen career will suffer greatly. We feel that in the major conurbations - London, Birmingham, Liverpool, Glasgow - there may be a sizeable pool of people known to carry the transmissible agent of hepatitis B. From time to time, such people will need, invasive procedures including surgery. We suggest that special units should be set up in these large centres, for elective and emergency surgery on these patients. The medical, nursing and other staff would be recruited from health professionals known to be carrying transmissible hepatitis B but otherwise fit. Our proposal cannot reverse human tragedy, but would enable continued use of special skills whilst diminishing the risks of further spread of infection. A similar approach to HIV infection could be considered in Greater London. The older generation will recall that the staff of TB sanatoria were often doctors, nurses and other colleagues who had suffered from tuberculosis. There was remarkable fellow feeling amongst the staff and patients which probably had a good therapeutic effect.

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Management of generalized faecal peritonitis

Scholefield *et al.* (November 1991 *JRSM*, p 664) reported a low mortality rate in their small series of patients with faecal peritonitis managed by an aggressive policy of repeated lavage and debridement.

Gram-negative septicaemia is one of the major factors associated with the high mortality of this condition, and endotoxins are believed to be the bacterial factors responsible for the systemic effects produced[1,2]. The use of the commercially available human monoclonal IgM antibody targeted against endotoxin (Centoxin) in such patients in association with repeated peritoneal lavage may help to further reduce mortality rates. The multicentre trial suggested by the authors could include randomization to receive Centoxin or placebo in order to evaluate the true potential of this treatment.

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