

that cardiac surgery were submitting externally. I felt that this national arena was the most appropriate way of dealing with cardiac surgery and provided a secure mechanism.

10. At audit meetings for general surgery one main topic would be chosen each month and morbidity and mortality data analysed. An example would be: the use of blood products and whether appropriate amounts were being ordered. Data would be collected for each topic. The length of time for which data had to be collected depended on the topic. Normally, 3 months of data was the minimum requirement and only then would the audit review/discussion be meaningful. Sometimes, for example, when looking at patients with ruptured aneurysms, we would need to run data for a year to assess the average mortality. This could be contrasted to a review of wound infections when data for a month would suffice because of the larger number of patients available to enter the study. This data was collected by junior doctors and cross checked at meetings.
11. Additionally, at every audit meeting for general surgery an SHO would critically present the charts and notes of an unnamed patient from another team's list. There would be discussions and suggestions for ways forward if problems were identified. In this way junior doctors became imbued with the process from an early stage.
12. By about 1994 we were developing clinical audit which involved nurses and other para-medical staff. Due to the number of people who needed to attend it was and still is a difficult activity to organise.
13. In addition there were some joint medical audit meetings with anaesthetists during the early 1990s. Cardiac surgery was never discussed in the general surgical directorate as it did not fall within this remit. No joint audit was carried out between general and cardiac surgery departments.
14. I have been asked to comment on my letter of 23 March 1993 to Dr Thomas, reference **UBHT 0027 0286**, at **Annex 3**. In that letter I referred to inappropriate