

all disciplines who were reluctant to participate and attend meetings. In order to ensure attendance in general surgery a register was kept and non attendance meant non-compliance. We worked towards gaining a more comprehensive, universal audit from all units. For many it was a change of culture. This contrasted to my own experience where I had been involved in unit audit activity since 1981 when I was first appointed as a consultant, and before that as a junior. For me case review and audit was a matter of good practice. Currently, for example, breast/endocrine audit occurs in two separate meetings each week. Audit in general surgery occurs across the city in Friday afternoon education sessions.

8. I understood the Cardiac Directorate was auditing its own work and submitting results nationally to a central registry in order that they could be compared with other units in the Country. The Cardiac Directorate did not submit its data internally as stated in my letter to Dr Stansbie on 22 March 1993, reference **UBHT 0027 0282**, at **Annex 2**. Data which involved cardiac surgery did not cross my desk and was not included in my report to Dr Thomas. I do not remember Dr Thomas wanting me to pursue this issue further. I think that I and the audit committee were happy that the cardiac unit were submitting to a national comparative audit. I felt that this was logical because of the highly specialised nature of cardiac surgery. It is a speciality that does not compare easily to any other sub-speciality. We knew that audit was taking place and at the time the focus was on getting audit carried out across the whole Directorate and in every sub-speciality of surgery.
9. My understanding of cardiac surgical procedures in general and their associated morbidity/mortality and, in particular paediatric cardiac surgery, was and is very limited. I would not have known the bench marks that the cardiac surgeons should have been achieving. Few other surgical sub-specialties have mortality and morbidity to match that of cardiac surgery. It is a very technical, high risk, area with no comparisons to general surgery. I knew that the cardiac surgeons were submitting data to a national audit where comparisons with other units would be made. The process should have identified problems and corrections to allow closure of the audit loop. When reporting to the Medical Audit Committee I informed them

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