Perioperative deaths among children

Standards of care are high, but those who don’t care for children regularly shouldn’t care for them at all

Society may be judged by the care it provides for its most dependent members. The decision that the first report of the National Confidential Enquiry into Perioperative Deaths should examine deaths among children aged under 11 within 30 days of surgery is therefore fitting, although it was also influenced by practical considerations. The long term aim of the national inquiry is to review 6000 deaths annually, but the logistic problems persuaded the steering committee initially to select a smaller, more easily defined sample. The resulting report, published this week, is the first time that a single surgical-anaesthetic specialty has been formally assessed in such detail.1

The report’s first conclusion, that the overall standard of surgical and anaesthetic care of children is excellent, is therefore a matter for satisfaction. Neonatal and paediatric surgery is a relatively new specialty, and progress in the care of children with both cardiac and non-cardiac conditions to the standards illustrated by the inquiry has also been due to the parallel development of specialist anaesthetic practice. This has played an important part not only in the operating theatre but also preoperatively in clinical assessment and postoperatively in the intensive care unit. Nevertheless, and unsurprisingly, there is room for improvement in both surgery and anaesthesia.

The desirability of children’s surgery and anaesthesia being performed by clinicians with a regular paediatric practice is clear—not least to those without such a practice who are forced by circumstances or staff shortages to care for children. The number of full time paediatric surgeons has increased in recent years, and now all teaching hospitals have full time paediatric surgeons (except in one region) and anaesthetists with specialist paediatric experience. But inevitably some work is done by general surgeons, and the report emphasises not only the importance of regular paediatric practice but also the problems posed by some locum staff not having the competence to care for children. The British Association of Paediatric Surgeons has produced guidelines on training for general surgeons who are responsible for children. Some years ago the Royal College of Surgeons of England suggested that in district general hospitals with four or more surgeons one should have had some training in paediatric surgery.

The inquiry underlined the accepted need for continuing postgraduate education for all consultants who care for children—particularly those in district and single specialty hospitals. In practice this probably entails their joining and attending the scientific meetings of specialty associations such as the British Association of Paediatric Surgeons and the Association of Paediatric Anaesthetists of Great Britain and Northern Ireland. General surgeons may not be aware that the British Association of Paediatric Surgeons would welcome them as members.

Single specialty units pose particular problems, which are likely to be resolved only by an increase in the number of medical and nursing staff trained in caring for children. Care for children could also be improved by a more widespread acceptance of the need for transfer, perhaps between regions, of children with complex surgical problems, notably those with burns or neurosurgical or cardiac conditions.

The report rightly emphasises the value of a team approach to caring for paediatric surgical patients. Training programmes in paediatric medicine should clearly include a period on a surgical unit, just as the training of general surgeons who will care for children should include close contact with paediatricians or paediatric surgeons. Nowhere is this cooperation more important than in the care of a severely injured child.

As in the original survey of perioperative deaths in 1987,2 this report emphasises the importance of supervision of juniors. Its final recommendation is that no trainee should undertake any anaesthetic or surgical operation on a child of any age without consultation with his or her consultant. But this is a counsel of perfection; with a consultant’s workload spread across more than one hospital it may be difficult to achieve. It also fails to acknowledge that many trainees in paediatric surgical and anaesthetic training programmes have reached a high degree of clinical and technical competence, certainly in the less than complex procedures such as routine circumcisions and hernia repairs in fit children.

The report’s first recommendation is that the National Enquiry into Perioperative Deaths should continue. Few will disagree, although both this and the 1987 report have probably done as much as is presently possible in encouraging better standards of care. High standards seem at present to be more at risk from deficiencies in resources than from deficiencies in training or supervision or audit programmes. Realisation of all six of the report’s recommendations (see p 1608) on ways to improve the surgical care of children will involve not only clinicians but also politicians and managers. If clinical information services are improved—another of the recommendations—then an even more formidable task may lie ahead: the investigation of perioperative morbidity.

MALCOLM H GOUGH
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