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At the recent Executive meeting of the ACPGBI, it was clear that the Association is in good shape, and that its agenda is growing exponentially! In a short newsletter it is impossible to cover all the issues, but I thought I would bring two issues to your attention – the recent report on the National Emergency Laparotomy Audit (NELA) and the vexed topic of medical manslaughter.

For most of us, whether we consider ourselves specialist colorectal surgeons or general surgeons with an interest in coloproctology, emergency laparotomy represents a significant component of our workload. The first report of the National Emergency Laparotomy Audit, which was commissioned by the Healthcare Quality Improvement Partnership (HQIP), was published in June of this year, and is available at www.nela.org.uk.

In this audit, data were obtained for over 20,000 patients in England and Wales (83% of all those eligible) and each hospital was provided with a breakdown of their performance against a set of standards encompassing the periods before, during and after surgery. Overall, the 30-day mortality was 11%, less than expected from previous reports, but still five times higher than that after high-risk elective surgery. In terms of adherence to the standards, there was significant variation between hospitals, with some meeting them in over 80% of cases, but many achieving only 60-70%. A number of recommendations were made, but foremost was the drive towards providing a consultant-led service in all situations.

This is a formidable piece of work that has the potential to greatly improve standards of emergency care, but there are some caveats. Firstly, there may have been a degree of under-reporting, and it will be important to obtain independently verified mortality data from National Office of Statistics. Secondly, there was variation in the degree of consultant

engagement in entering data, and it is really important for the accuracy of this information for surgeons to take ownership of their own data. Thirdly, there has been some confusion surrounding definitions, especially that of defining the "senior surgeon", and it would be useful to have more clarity in this area. Fourthly, in NBOCAP, surgeons have the opportunity to review their data prior to publication, and, if applied to NELA, this might avoid loss of cases. Fifthly there is concern that palliative procedures are being included along with potentially curative laparotomies, and it might be useful to treat these a separate group to avoid the possibility of surgeons shying away from this important area of practice. Finally, when data are sent to hospitals, it should be made clear that individuals should not be treated as outliers on the basis of small numbers of cases.

Clearly, there remains room for improvement in the outcomes from emergency laparotomy and this report clearly lays out both problems and solutions.

It will, however, require engagement from surgeons, prioritisation of resources into emergency care, and consideration of damage limitation surgery with transfer to tertiary care where appropriate.

Turning now to medical manslaughter, last year's custodial sentence for David Sellu on the grounds of gross negligence manslaughter, has raised very real concerns for the medical profession in general. For colorectal surgeons, this is particularly worrying given that we shoulder the lion's share of emergency surgery, and that our elective work is often high risk. This tendency is not going to go away, and it is therefore very important to learn from medical manslaughter convictions so that we know how to protect ourselves as well as our patients. It is also important to be clear about how to behave when things do go wrong.

The Medical Protection Society have a very useful article available on their website in which Norman Williams comments on the implications of recent relevant cases. The law, as it stands, recognises the elements of Medical Manslaughter to be that the defendant has breached a duty of care, that this breach significantly contributed to the victim's death, and that the breach was grossly negligent. It is up to the jury to determine the extent of the negligence.

According to Professor Williams, the implications for a surgeon of the Sellu case are firstly to write down everything relating to a consultation in legible handwriting so that it is very clear exactly what has been discussed with the patient. It is also critical that consent for any procedure must be fully informed and that all the pros and cons have been laid out in a way that the patient understands. In Professor Williams' words "it also

goes without saying that you have to be compassionate and caring".

When things do go wrong, as they will for all of us, being completely open and communicating effectively with the patient and/or their relatives is central to a satisfactory resolution of the situation. This will mean, in many instances, delivering a sincere apology and a careful explanation of the events that have led up to the adverse outcome.

Of course, gross negligence is something we should all strive to avoid at all costs, and no amount of record keeping and explanation will alleviate this should we be truly guilty. However, we should bear in mind that the concept of gross negligence is one of interpretation by a jury, and if it is absolutely clear what has been discussed with a patient, and that correct procedures have been followed, it is extremely unlikely that unintentional harm will be misconstrued as grounds for a conviction of manslaughter.

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