CHASM
Collaborating Hospitals'
Audit of Surgical Mortality
Clinical Excellence Commission

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Dear Surgical Fellow

Following approval by Ms Elizabeth Koff, Secretary, NSW Health, I am pleased to provide you with an electronic copy of the CHASM Casebook 2018. This casebook has been redesigned for a broader audience with information and data that is applicable not only to surgery, but to areas of patient safety and quality improvement. It is a compilation of six de-identified case examples highlighting different areas of risk, complexity and complication; five clinical reviews from members of the Committee, and; program information and data on the deaths notified for the 2018 calendar year.

There is no specific theme for this publication, rather it provides examples of the complexities associated with challenges around the *decision to operate, patient expectations, managing high-risk patients and, the awareness and recognition of post-operative complications*.

While reading this publication, I hope you will take the opportunity to engage in some reflection on your own practices, and the environment in which you perform surgery, as the most beneficial part of peer review is the provision of self-improvement through the process of self-reflection.

CHASM is a not a performance-based program, but one of peer review and reflection conducting expert, independent assessments on surgical mortality. The feedback is provided directly to the operating surgeon/s for each case and is protected under the *Health Administration Act 1982* as specially privileged information.

I would like to take this moment to express my gratitude for your participation in the New South Wales Collaborating Hospitals' Audit of Surgical Mortality (CHASM). Your submissions and contributions to this valuable program are appreciated.

If you would like further information about the CHASM Program, please email:
CEC-CHASM@health.nsw.gov.au

Yours sincerely,

Dr David Robinson
Immediate Past Chairman, CHASM Committee