The phrase 'bury your head in the sand' means failure to acknowledge a problem. It emanates from the habit of ostriches who hide when faced by predators with the critically flawed assumption that if you can't see it, it can't see you. The obvious shortcoming of Surgeon Specific Mortality Data (SSMD) is the premise that the surgeon bears responsibility for all postoperative deaths irrespective of clinical circumstance. This devalues the surgical team approach and completely ignores the fact that hospital staffing, infrastructure and process underpins patient safety.

The paper by Westaby et al. is a very welcome contribution, which injects an element of truth and common sense into this controversial area [1]. SSMD were documented to cause risk-averse behaviour and gaming with risk assessment on a widespread scale in the USA [2]. As the paper indicates, the USA actively discouraged this approach and replaced it with quality measures, which addressed hospital infrastructure.

Using phase of care mortality analysis and careful scrutiny of the causes of mortality, the authors show failure to rescue (FTR) to be the root cause of a large proportion of fatal events. Every cardiac surgical service is familiar with the same situation. Therefore, attributing all deaths to the surgeon in the public arena is dishonest and damaging [3]. Factors that underpin FTR are described in the paper with an emphasis on team consistency and problems with temporary staff who inevitably detract from coherent teamwork. A recent newspaper article states that UK Foundation Hospital Trusts spent £400 million on locum doctors and agency nursing staff in 3 months [4]. This follows difficulty in recruiting staff to fill vital posts long term and goes some way to explain infrastructure issues highlighted in the paper. The absence of ECMO and other circulatory support technology on financial grounds compounds the problems and is a cost issue and is purely an economic issue. As a pioneer of circulatory support, Westaby has campaigned against this deficiency for many years [5].

The authors have provided clear evidence that death is inherent in systems and not dependent on individual surgeons. Very few deaths occurred through poor surgical performance and overall mortality was precisely as predicted from the EuroSCORE model used. The public should be reassured by the fact that UK surgeons are safe but be concerned about NHS structure and process that underpin FTR. More comprehensive albeit expensive systems of outcome reporting have a greater likelihood of improving quality without the negative consequences of SSMD. All cardiac surgeons understand that postoperative management is critically important but that the experience of surgical and anaesthetic trainees who bear responsibility of out of hours care is variable. Quality and education of nursing staff affects their ability to recognize the importance of a complication and initiate a management strategy. When deaths do occur, many result from errors in judgement or omission. The authors therefore propose a more comprehensive method of outcome reporting, which takes into account institutional factors as well as the surgeon. The British National Health Service therefore needs its own 'Star rating system' along the lines of that in the USA.

Lastly, quality and safety in surgery depends on timely adoption of new technologies and equipment. This is dependent on funding, education, staffing and research but medical advances and cost containment do not sit well together. In the USA, higher volume centres are associated with lower FTR rates because high volume is associated with economic benefits. Enhanced nurse-to-patient ratios, number of intensive care unit physicians, availability of circulatory support technology and protocol-based policies for timely recognition of adverse events are characteristics of high-volume low-FTR centres. Thus, institutional factors, not surgeons, confer the strongest influence on mortality rates from postoperative complications.

The authors should be congratulated for highlighting these issues from the UK. Hopefully, this will trigger much needed debate about the validity of SSMD, a process that causes significant problems with recruitment to the specialty. As a training programme director, I am continuously exposed to the problems caused by European Working Time Directive and fear of public exposure following mortality reporting. Fewer surgeons are prepared to let trainees operate on their patients. To live in the utopian world of zero mortality is unreal and it is time we raised our heads to confront the threats of SSMD to the patients and profession alike.
REFERENCES


