When is the burden of responsibility over for the surgeon?

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To many, the safe conduct of an operation and the successful discharge of a patient is the summation of the surgeon’s responsibility. While this is the fundamental responsibility of a surgeon, our role in both the preoperative and postoperative periods has never been more important. One does not have to look too deeply into the literature to see that operative mortality can be defined in many ways, but when we extend the follow-up timeframe, that number becomes frighteningly higher [1, 2].

Operative mortality in most countries has fallen continuously over the last decade. Improved risk stratification, anaesthetic care, pain control and the ability to rescue critically ill patients have all incrementally pushed down our in-hospital mortality. These changes in the perioperative period can set off a cascade of events extending into the postoperative timeframe that can lead to the death of patients after they are discharged. In many cases, we have identified risk factors for those deaths, yet we still struggle...
with how to minimize it [3]. In contrast, post-discharge mortality has not improved with time, and suggests that our improved peri-operative care has not affected this interval.

The study by Green et al. [4] published in this journal is a good example of how fastidious documentation and evaluation can both show the burden of a problem and give hints on where to focus our attention. They do a very good job of thoughtfully applying risk stratification to their patient population on a national level and using that available data to identify a high-risk group. Many of these results have face validity. I think most surgeons would worry more about older, more comorbid patients and patients with adverse events, but the findings from this study suggest that male patients with more complex surgery also warrant increased attention. The secondary benefit of this evaluation in the Danish group is the ability to benchmark themselves to ensure internal consistency and also to measure continuous improvement. This is an ability that most countries lack, but is fundamental to improvements in care.

The challenge is what to do next with this information. Clearly, there is an unmet need for postoperative care. Like many journeys, the burden of postoperative care seems to extend to the horizon. This study further emphasizes the need for further study into this area and is a rallying cry for surgeons to intensify their efforts on their postoperative care.

REFERENCES