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## Tracking outcomes in surgical care

In this issue of the *Canadian Journal of Surgery (CJS)*, 2 centres have published outcomes of their programs' care during the early part of their experience. Andrew and colleagues<sup>1</sup> discuss the outcomes of laparoscopic Roux-en-Y gastric bypass for the treatment of obesity in relation to the early part of surgeons' learning curve; they demonstrate acceptable and improving outcomes as the learning curve is addressed. Milman and Ng<sup>2</sup> report early outcomes of treatment for complex thoracic surgery procedures, based on the experience of their surgeon leader, who recently graduated from Canadian surgical training programs. This latter study reports satisfactory outcomes that compare favourably with other centres with greater experience and a higher volume of patients. The authors of both manuscripts are to be commended for reporting their experience during a particularly sensitive time in the evolution of their programs.

These 2 studies reflect the current tone set by the public and by ministries and funders who are taking a probing look at outcomes as a measure of the quality of care delivered. As stated in both manuscripts, bariatric surgery programs and chest surgery programs have been under scrutiny to show that good outcomes have been related to the volume of surgical procedures and, by inference, to improved outcomes of care. Taken together, questions arise concerning how centres of subspecialization should be set up and how their outcomes should be assessed. Finally, should these areas of subspecialty expertise be further developed into "centres of excellence?"

How should we establish excel-

lence in subspecialty care? Surgery has a long history of improving quality outcomes through coordinated approaches. A typical example is improved approaches to the care of injured patients through the Advanced Trauma Life Support programs. The essential ingredients of this require several commitments. There must be a well-organized plan with outstanding leadership and resource standards that provide essential facilities to establish care. Process of care standards, including care maps and clinical pathways, have yielded consistent surgical outcomes. A method for capturing data to track outcomes is essential, and the standards must be verified by accreditation. As stated by Andrew and colleagues, several specialty societies have prepared specific recommendations regarding experience, training and proctoring to safely perform laparoscopic bariatric surgery. In addition, success requires a multidisciplinary team approach. This is acknowledged by Milman and Ng, who identify the disciplines of anesthesia, medical subspecialty expertise, radiology, pathology, critical care and oncology as necessary in the adequate treatment of patients who need chest surgery.

Crucial to the success of developing subspecialty expertise is the tracking of accurate data. Milman and Ng suggest using a database that tracks the results of procedures performed by graduates of various training programs and pathways. It is important for surgeons to be at the forefront of creating these tracking mechanisms. A major challenge is to ensure that all data allow for stratification of risk. This remains a major

impediment to the adequate comparison of outcomes between centres and perhaps for individual surgeons. The American College of Surgeons through the National Surgical Quality Improvement Project (NSQIP) has made significant progress in this area by developing risk-adjusted outcome reports. There can be issues of privacy that limit applications of NSQIP in Canada, but some of our health regions have been able to accommodate this project with assurances of data protection.

Should areas of subspecialty care be increasingly focused on “centres of excellence?” The American College of Surgeons has recently attempted to set some standards regarding the development of subspecialty expertise. These have included cancer care models, bariatrics and breast disease management. How will this affect generalist surgeons who are broad-based, first

responders to difficult decisions in surgical care? Accurate data must be used to refine the definition of subspecialty care to be provided in such centres. It may not be wise to call these “centres of excellence,” since this degrades the importance of other decisions made in good surgical care. Perhaps a “centre of excellence” should be viewed in a functional sense, as a network program in which some procedures are performed in high-volume sites, while others can fit into the program where care can be provided at the local hospital. The accurate tracking of data will remain a challenge; however, some disciplines, such as transplantation, have managed to overcome these problems by constructing registries that report and follow-up data in a timely fashion.

In summary, quality surgical outcomes are everyone’s business. The challenges to upgrade training

programs must be matched by careful leadership and standardization of resources and processes of care. The tracking of outcomes and verification of standards is essential, and surgeons need to be involved in the definition of these outcomes. Two examples for bariatric and chest surgery provided in this issue of the *CJS* show how to do it right!

**Garth L. Warnock, MD**  
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### References

1. Andrew CG, Hanna W, Look D, et al. Early results after laparoscopic Roux-en-Y gastric bypass: effect of the learning curve. *Can J Surg* 2006;49:417-21.
2. Milman S, Ng T. Initial clinical outcomes after completion of training in a Royal College of Canada thoracic surgery program. *Can J Surg* 2006;49:422-6.

## Le suivi des résultats en soins chirurgicaux

Dans ce numéro du *Journal canadien de chirurgie (JCC)*, deux centres ont publié les résultats des soins dispensés par leurs programmes de chirurgie au début de leur expérience. Andrew et ses collaborateurs<sup>1</sup> discutent des résultats d’un pontage gastrique laparoscopique de Roux-en-Y contre l’obésité, en regard du début de la courbe d’apprentissage des chirurgiens. Ils démontrent que les résultats sont acceptables et s’améliorent à mesure que l’on progresse sur la courbe d’apprentissage. Milman et Ng<sup>2</sup> font état des premiers résultats du traitement dans le cas d’interventions chirurgicales thoraciques complexes, en se fondant sur l’expérience de leur chirurgien chef qui a terminé récemment un programme canadien de formation en chirurgie. Cette dernière étude fait

état de résultats satisfaisants qui se comparent favorablement à ceux d’autres centres plus chevronnés et recevant plus de patients. Il faut féliciter les auteurs des deux manuscrits d’avoir relaté leur expérience pendant une période particulièrement délicate de l’évolution de leurs programmes.

Ces deux études reflètent l’atmosphère établie actuellement par le public, les ministères et les bailleurs de fonds, qui examinent de près les résultats pour mesurer la qualité des soins. Comme on l’indique dans les deux manuscrits, on a scruté de près les programmes de chirurgie bariatrique et de chirurgie thoracique pour démontrer que les bons résultats sont reliés au volume des interventions chirurgicales et, indirectement, à l’amélioration des résultats

des soins. Dans l’ensemble, des questions se posent sur la façon d’établir les centres de surspécialisation et d’évaluer leurs résultats. Faudrait-il pousser plus loin l’évolution de ces domaines de surspécialisation pour en faire des «centres d’excellence»?

Comment faudrait-il réaliser l’excellence des soins surspécialisés? La chirurgie a une longue histoire d’amélioration des résultats par la coordination. L’amélioration des modèles de soin des patients traumatisés dans les programmes de techniques spécialisées de maintien des fonctions vitales en est un exemple typique. Or, les éléments essentiels de cette amélioration exigent plusieurs engagements. Il doit y avoir un plan bien organisé et dirigé par des chefs de file exceptionnels dont les normes sur les ressources prévoient des