

Regarding the percentage change in ELV after lavage, the trend at different positive end-expiratory pressure levels with ELV was more uniform than end-expiratory lung volume, which may reflect that the former is a functional volume parameter and not a measure of anatomical volume. Furthermore, the ELV value is the only lung volume assessment available at bedside for the clinician, and any recruitment maneuver will be based on the changes in this index. Accordingly, the aim of the clinician will be to re-establish its former value by recruitment maneuver, which eliminates the risk of lung overdistension. It is noteworthy that the lavage-induced decreases in ELV follow a more uniform pattern than end-expiratory lung volume.

There is no doubt that measurement of different lung functional parameters is necessary to reinforce the detection of airway closure and/or reopening. Accordingly, it is very hard to promote one single measure in clinical practice to guide ventilation strategy. Measuring ELV may contribute to better understand the changes observed in respiratory mechanics, but it cannot be considered as a single parameter to detect loss in lung volume. Particularly, changes in pulmonary blood volume may interfere with its absolute value as discussed in the article, which is more obvious at low positive end-expiratory pressure levels. Nevertheless, this method is under improvement and continuous development by our research team. We are currently investigating the relation between ELV and structural global and regional changes in the lungs to improve the algorithm.

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Competing Interests

Drs. Wallin and Hallböck work at the Research Development Department of Maquet, Solna, Sweden, and they established the theoretical bases of the measurement technique tested in the corresponding article.

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Pain-free Surgery or Pain-free Parking: Measuring Patient Satisfaction with Perioperative Care Is Humbling for the Anesthesiologist

To the Editor:

Barnett *et al.*¹ are to be thanked and congratulated for their attempted synthesis of efforts to quantify patient satisfaction with anesthesia care. The authors did not include the Surgical Consumer Assessment of Healthcare Providers and Systems® (CAHPS) in their assessment, which deserves discussion.²

Surgical CAHPS is the newest member of the CAHPS family and is the only tool measuring patient satisfaction with surgical (or anesthesia) care which is endorsed (in whole or in part) by the National Quality Forum, the main clearing-house for performance measurement in health care.* Surgical CAHPS was designed by the American College of Surgeons with the Agency for Healthcare Research and Quality to be psychometrically rigorous. The instrument incorporates information from multiple care streams and providers of perioperative care—surgeon, nurse, anesthesiologist, hospital, and clinic.

Although four of the seven selected measures ask about the “surgeon,” none ask about anesthesia care. When adopting and endorsing Surgical CAHPS as a publicly reportable performance measure (NQF #1741), the National Quality Forum included fewer than half of the questions making up the tool. Psychometric properties were ignored. Our specialty and the care we provide for patients were also ignored. Although four of the seven selected components ask about the “surgeon,” none ask about anesthesia care.

Rather than feel “snubbed,” perhaps we anesthesiologists may find a pause point to imagine care from the perspective of the patient. For a “person” who becomes a “patient,” the lines separating surgery, nursing, anesthesia, and pain-free hospital parking can easily blur. This, of course, is why using a psychometrically rigorous instrument can be important, especially for targeting specific areas for improvement. But in practice, applying lengthy instruments for each component of perioperative care may induce survey fatigue in our patients and compromise the results of such surveys. More importantly, our patients are frequently unaware that we are physicians or that anesthesia care matters, as the American Society of Anesthesiologists’ “Physician Anesthesiologist” campaign points out.† As physicians practicing medicine, our goal is not to meet quarterly anesthesia satisfaction benchmarks but to earn patient loyalty by assuring that our patients are cared for—period.³ Embracing this concept would cement our role as perioperative physicians and align our goals with those of surgeons, nurses, hospitals, and, most importantly, our patients.

* Available at: <http://www.qualityforum.org>. Accessed September 12, 2013.

† Available at: <http://www.asahq.org/WhenSecondsCount/>. Accessed December 3, 2013.

Competing Interests

The author declares no competing interests.

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In Reply:

We would like to thank Dr. Hyder for his interesting and pertinent comments.

Dr. Hyder is correct. We did not include the surgical Consumer Assessment of Healthcare Providers and Systems® within our review¹ for the very reasons he states. It considers too many aspects of hospital care to be able to provide specific, reliable information on patient satisfaction with “anesthesia.” We agree wholeheartedly that a huge part of the anesthetists’ role is to act, in effect, as a patient advocate, and to ensure that they are “cared for-period.”

However, here in the United Kingdom, we are required by the Department of Health to provide evidence that our speciality is providing top quality care. As a result, it seems prudent to ensure that we provide this information in an accurate and unbiased manner. This is made more likely through the use of speciality-specific, psychometrically developed tools which can allow an accurate data collection and benchmarking of results.

Our role as “perioperative physicians” is expanding and we hope to be valued, not only for our clinical excellence but also for our high-quality communication skills and empathy toward patients and relatives. In order to produce “transparent” evidence to our patients and governments, a speciality-specific instrument becomes essential. Only when we collect quality data explicit to anesthesia using concise, “non fatigue-inducing” questionnaires can we truly comment on our salient role within health care.

Competing Interests

The authors declare no competing interests.

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Race Still Matters: The Disturbing Persistence of Racial Disparities

To the Editor:

I read with great interest the article by Silber *et al.*¹ reporting a statistically significant increase in operative times between black and white Medicare patients who were very closely matched for age, sex, procedure, comorbidities, hospital, risk score, and body mass index. Particularly striking is the finding that when the difference in procedure times was greater than 30 min, black patients were significantly more likely to have the longer procedure time (a worse surgical outcome).

The literature documenting racial disparities in health and health care is extensive, particularly in the primary care and public health arenas. Large, systematic studies looking at racial disparities in surgical care and outcomes have been far fewer and have recently concentrated on surgical volume of the hospitals attended as the chief cause of disparity. A large study in 2005 using the Medicare database confirmed earlier findings that blacks are consistently more likely to die after major surgery and attributed this mortality difference mainly to low surgical procedure volumes at the hospitals attended.² A study in 2006 of racial disparity in surgical complications between black and white patients based on New York State hospital discharge data found that these differences were due mainly to comorbidities and hospitals attended,³ and a study in 2010 matched for comorbidities and essentially replicated those findings.⁴

Yet after matching for comorbidity and hospital, a racial disparity in operative time, another clinically significant surgical outcome, still persists. What explains this? The authors posit but did not match for ecological factors. Their study would have been helped enormously by matching for income and education. They also speculate about racial disparity in who performs the surgery (attending *vs.* resident surgeon) but admit that these data cannot be captured from Medicare claims data or chart abstracts. A study examining racial disparity in operative times between similarly matched Medicare patients at nonteaching hospitals could be designed to indirectly address that question. Questions such as these must be