of the EuroSCORE using data from the whole of Austria. Since on the basis of the above criteria the EuroSCORE has been selected for the calculation of result quality, the demand must be made that this decision should also be secured from a medical aspect after sufficient data material has become available.

References


ICVTS online discussion A

Title: EuroSCORE and specialised databases
Author: Narcis Hudorovic, University Hospital Sestre Milosrdnice, Zagreb 10000, Croatia
doi:10.1510/icvts.2007.153056A

eComment: The EuroSCORE is probably refined enough for improved informed consent versus aggregated results but should only be used for inter-institutional benchmarking with great caution. In a regional context, the system of continuous monitoring of hospitals’ clinical performance relies on the regional hospitals’ databases. The most valid feature of these databases is the inclusion of a description of patient’s surgical risk expressed through the EuroSCORE [1]. Maybe, the most valuable tool to improve quality monitoring system is implementation of a regional registry of patients undergoing cardiac surgery. Specialized clinical databases are a more clinically oriented source of information and they improve case-mix adjustment procedures and provide more accurate mortality figures for each centre. There is a consensus in a surgical community on the need for monitoring hospital performance, it should be noted that the choice of one source of information over another implicitly implies also a choice between different approaches to quality improvement and models of accountability [2]. In such a context, the main added value of clinical databases is the degree of direct participation of surgical teams required by their implementation.

Three years ago, we started to construct our regional cardiac database. The process of registry development showed that patients with cardiac disease who experienced combat situations seemed particularly troubled by enhanced emotionality. War veterans with cardiac disease clearly regarded themselves as irritable, tense and moody worriers. Sensitization was another characteristic found in these patients with/without cardiac disease. The combination of the above items might support Byrnes view that manifest cardiac-prone behaviors arising from an underlying existence of competitiveness achieve their greatest pathophysiological toxicity if their expression and realization are frustrated. As we expected, neuroticism played a major role in the creation of cardiac registry because these patients must be properly included or excluded in the database. Until today, we have not been able to properly resolve the problem of evaluation and scoring of these patients within the regional database. The experience of the Austrian colleagues will certainly help us.

In summary, selection of a predictive model of the Austrian cardiac register [3] seems promising. Exciting the adverse event rates in regional cardiovascular departments must be of continuing concern and underlines the need for continued quality improvement efforts and creation of regional clinical databases to provide valid measures of outcome.

References

