Perioperative medicine- the second round will need a change of tactics

H. Kehlet1,*, C. P. Delaney2 and A. G. Hill3

1 Section for Surgical Pathophysiology, Rigshospitalet Copenhagen University, Rigshospitalet, Blegdamsvej 9, Copenhagen 2100, Denmark,
2 Digestive Health Institute, University Hospitals Case Medical Center, Case Western Reserve University, Cleveland, USA, and
3 Department of Surgery, Middlemore Hospital, University of Auckland, Auckland, New Zealand
*Corresponding author. E-mail: henrik.kehlet@regionh.dk

Implementation of the concept of ‘perioperative medicine’ is by definition – and as emphasised many years ago – a multidisciplinary effort involving anaesthetists, surgeons, nurses and physiotherapists where appropriate. Going back in history, ‘perioperative medicine’ has been around for more than a decade, but the name of a thing itself may not be as important as to how we identify it and document its relevance. In this context, the recent editorial by Cannesson and colleagues reemphasises the importance of ‘perioperative medicine’, but with a major emphasis on the role of anaesthetists. The arguments include that ‘new delivery of care models all have in common that it is anaesthetists that often are leading them’, that ‘the nature of anaesthetists’ training and practice make them natural candidates to become leaders of the perioperative environment’ and that anaesthetists are ‘system thinkers’ arguing for an expanded role to secure ‘the position as leaders in the hospitals’. They also argue that innovative models such as Enhanced Recovery After Surgery (ERAS) and The Perioperative Surgical Home (PSH) are important. It is noteworthy that throughout the editorial, there is no mention of the word ‘surgeon’ or ‘surgical care principles’.

In order to secure progress in perioperative outcomes, we would reiterate that these efforts should be based on a multidisciplinary basis, as emphasised from the beginning, later and more recently. In this context, it has been surgeons who most often have been involved in the development and documentation of the value of enhanced recovery programs/the fast-track methodology. Thus, a key point to improve outcome, has always been that initial optimised interventions pre- or intraoperatively, will not automatically translate to an improved outcome, unless the surgeons and surgical nurses integrate these evidence-based components of care into the overall postoperative surgical care package, and especially that provided during the days in hospital, after the stay in the postoperative care unit.

That a multidisciplinary approach is a prerequisite for optimising recovery, has been clearly demonstrated by the problems of interpreting the many studies on unimodal interventions with optimised analgesia. For example epidural analgesia, different interventions for fluid management, or minimal access surgery, where progress and clinical relevant recommendations have been delayed, or perhaps inappropriately been introduced because the specific intervention was not investigated, in the context of an otherwise updated evidence-based optimised care program.

Consequently, future strategies to improve perioperative outcome, within the context of anaesthesiology, surgery, nursing care and perioperative medicine, require a change of tactics going beyond politically and profession-specific approaches, but instead incorporating a multidisciplinary effort to achieve optimal outcomes. Leadership should be based on those persons/professions in individual institutions, that have demonstrated expertise to optimise outcomes, rather than be the sole responsibility of a single profession. As emphasised by Mencken many years ago: ‘For every complex problem there is an answer that is clear, simple, and wrong’. Hopefully, the professionals involved in organisation of perioperative care will react carefully and appropriately, as history has shown that otherwise the ‘knowing-doing gap’ between scientific evidence and clinical perioperative practice will not be reduced.

Declaration of interest
None declared.

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