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 review[1] 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

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