

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.

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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

asked and answered before we can hope to discern the causes of unfair disparities, which threaten our patients' health. This article models a well-designed study for doing just that.

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The author declares no competing interests.

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In Reply:

We appreciate the recent letter by Dr. Wilson and would like to expand upon some of the insightful points he raised. The goal of our study¹ was to determine whether racial differences in body mass index (BMI) could account for the differences in operative time which we had observed across black and white patients in a previous analysis in a different population of Medicare patients undergoing surgery.² In the current study, we carefully assessed both operative time and BMI through new chart reviews of 15,914 patients. In so doing, we observed two main findings. In the Medicare population over 65 yr of age, BMI is similar between whites and blacks, and differences that did occur in BMI did not account for the significant difference in operative time observed by race.

It is important to remember that for a confounder to affect a study on race, it must both be associated with race and influence outcome. Obesity was a plausible confounder. It may have been associated with race and it is associated with longer procedure time for some procedures. We found a weak association of BMI with race which we removed by matching. After matching closely on principal procedure, secondary procedure group, the individual hospital where the treatment was performed, a mortality risk score, a propensity score to be black, an expected time score based on principal and secondary procedure, 29 patient comorbidities, including

congestive heart failure, arrhythmia, past myocardial infarction, hypertension, diabetes, renal disease, chronic obstructive pulmonary disease, asthma, stroke, and dementia, age, sex, and BMI, the study continued to find a significant difference in the length of the operative procedure. This difference occurred almost completely between the “cut-to-close” interval, not between the “induction-to-cut” or “close-to-recovery room” intervals. None of the three articles cited by Dr. Wilson accounted for BMI differences when examining why outcomes differed between black and white patients.

We did not adjust for socioeconomic status variables such as neighborhood level poverty or education, or the Dual-Eligibility status of Medicare recipients. Our belief is that a black–white disparity that can be explained away by income or socioeconomic variables is still a black–white disparity in health care. Such a disparity remains a source of concern, even if it occurs also among poor whites. A disparity in operative time should not exist if adequate medical covariates have been accounted for. The strength of studying operative procedure length is that, for biologically similar patients, operative time is an outcome determined purely by the healthcare system. A long operative time cannot be ascribed to a failure on the part of the patient.

We agree with Dr. Wilson that further analyses examining socioeconomic status may be useful, especially in helping determine what processes occur inside the hospital that may lead to this observed racial disparity. An understanding of the process that produces a disparity can be helpful when trying to eliminate it. Nonetheless, if a racial disparity in health care disappears when adjustments are made for income, it still is a racial disparity.

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