The patient's outcome, not the surgeon's opinion, defines surgical success

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In contrast to the editorial, *Defining Surgical Success,* we advocate for including the voices of patients and parents when defining how successfully children with surgical conditions have been treated.

The editorial proposes, without supporting evidence, definitions of successful treatment of key conditions. For children with oesophageal atresia, the definition proposed is "*the child leaves hospital neurologically intact and feeding orally following one thoracotomy"*. This definition ignores the fact that parents and patients have highlighted how problems caused by oesophageal atresia often continue throughout life(1). The definition proposed for Hirschsprung's disease, *"a child leaving hospital defecating through their anus after one laparoscopic procedure*", is similarly problematic. Currently, 60% of children with Hirschsprung's disease are incontinent of faeces at primary school(2). Many of these children will have left hospital defecating through their anus after one laparoscopic procedure. Given the importance of faecal continence to patients(3) it is likely these children would consider their treatment more successful if they were continent, but had undergone alternative surgical management.

Rivero-Arias et al's Treatment Success Score(4) was developed using a preference elicitation exercise, including responses from clinicians, patients and parents, to provide a measure of how successfully a child had been treated for a surgical condition. This measure was designed to provide an assessment of the ***overall*** success of the child's treatment. The arguments and definitions proffered in the editorial fit more with measuring ***operative*** success rather than ***overall*** success. Given that these children's health and wellbeing is determined by so much more than an operation, measuring only ***operative*** success risks missing measuring what is important. Those best placed to provide valuable insights into the overall success of treatment, and therefore to input into how this is measured, are the patient, their families, and the multi-disciplinary team caring for the child (https://hexi.ox.ac.uk/parents-experiences-neonatal-surgery/overview).

In the preference elicitation exercise, participants were shown pairs of scenarios describing what happened to a fictitious child after treatment for a surgical condition. Participants were asked to choose which scenario in each pair described the more successful result of the child's treatment (fig.1). The editorial states that "*Certain deficiencies are obvious [with the Treatment Success Score]. Is it realistic for the general public to understand a complication following oesophageal atresia surgery […..] While medical paternalism is out of fashion, there are still times when an experienced surgeon is the only opinion which counts"*. We believe it is realistic for someone to assess the outcome of an operation without detailed knowledge of how it was performed. To suggest otherwise is disappointingly patronising.

Any Treatment Success Score will have limitations. However, incorporating the patient and parent voice alongside that of multi-disciplinary clinicians ensures that, unlike the definitions proposed within the editorial, the score developed is meaningful, and applicable throughout a child's life. We are pleased the Editors have highlighted that families may view success differently to clinicians (https://adc.bmj.com/content/109/5/i) and clarified the importance of an objective, patient-centred measure of treatment success.

1. TOFS. TOWARDS A HOLISTIC MODEL FOR THE TREATMENT OF THOSE BORN WITH OESOPHAGEAL ATRESIA (OA) FROM DIAGNOSIS TO TRANSITION AND ADULT CAR. 2021.
2. Allin BSR, Opondo C, Bradnock TJ, Kenny SE, Kurinczuk JJ, Walker GM, et al. Outcomes at five to eight years of age for children with Hirschsprung's disease. Arch Dis Child. 2020.
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