**Surgeon-specific mortality data: bury your head in the sand**

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The phrase ‘bury your head in the sand’ means failure to acknowledge a problem. It emanates from the habit of ostriches who hide when faced by predators with the critically flawed assumption that if you can’t see it, it can’t see you. The obvious shortcoming of Surgeon Specific Mortality Data (SSMD) is the premise that the surgeon bears responsibility for all post-operative deaths irrespective of clinical circumstance. This values the surgical team approach and completely ignores the fact that hospital staffing, infrastructure and process underpins patient safety.

The paper by Westaby et al. is a very welcome contribution, which injects an element of truth and common sense into this controversial area [1]. SSMD were documented to cause risk-averse behaviour and gaming with risk assessment on a widespread scale in the USA [2]. As the paper indicates, the USA actively discouraged this approach and replaced it with quality measures, which addressed hospital infrastructure.

Using phase of care mortality analysis and careful scrutiny of the causes of mortality, the authors show failure to rescue (FTR) to be the root cause of a large proportion of fatal events. Every cardiac surgical service is familiar with the same situation. Therefore, attributing all deaths to the surgeon in the public arena is dishonest.

Factors that underpin FTR are described in the paper with an emphasis on team consistency and problems with recruitment to the specialty. As a training programme director, I am continuously exposed to the problems caused by European Working Time Directive and fear of public exposure following mortality reporting. Fewer surgeons are prepared to let trainees operate on their patients. To live in the utopian world of zero mortality is unreal and it is time we raised our heads to confront the threats of SSMD to the patients and profession alike.

**REFERENCES**


