Patients' responsibility on reducing surgical morbidity and mortality

With public reporting we will all have report cards showing our outcomes of surgery as measured by complications. While some complications are technical in nature and attributable to our ability and efficiency most complications are multifactorial. Among the many factors there are some factors that are under the patients' control: eating habits, substance abuse and exercise. We cannot blame a patient for having a gene mutation that predisposes him to cancer. However, we cannot keep trying to repair ventral hernias in morbidly obese patients who don't get serious about losing weight.

It is pretty clear that obesity has a negative impact on the outcome of surgery. Surgical dissection and exposure is much more difficult placing vital structures in the field of surgery at greater risk and leading to more bleeding. Obese patients are also more prone to wound complications: dehiscence, evisceration, and infection. Surgeries that are started through a minimally invasive approach often need to be converted to an open approach in obese patients. This makes surgeries lengthier and more costly as well.

The deleterious effects of smoking on surgical recovery are well documented. Smokers have wound complications from poor wound healing and chronic cough. They also tend to have pulmonary complications (atelectasis and pneumonias) from their mucorrhea and chronic obstructive pulmonary disease. Sedentary life is associated with a higher risk of deep vein thrombosis, decreased muscle tone and easy fatigue, decreased lung capacity and cardiac reserve.

Surgeons are very familiar with all these facts and yet they proceed with elective surgery in patients who have made no attempt to correct any of these risk factors. One of the reasons to proceed with surgery in unfit patients is simply not to offend them by discussing their unhealthy behavior. Embarking in a conversation about life style can ruin the rapport one may already have with the patient.

As uncomfortable as it is surgeons are beginning to tackle some of these problems. At one center performing large volumes of esophageal and lung surgery they admonish patients to refrain from smoking for at least 3 weeks prior to surgery and inform them that if they fail a nicotine test the day of admission the surgery will be cancelled.

Obesity is much more prevalent and even more difficult to control than smoking. While the tobacco industry has been restricted in advertisement the food industry is constantly inducing people to add more calories to their diet. Ironically, foods of higher caloric value can be cheaper than foods with lower caloric value.

Recognizing that losing weight is not an easy task should not be a deterrent to require from patients a demonstrable effort to losing weight prior to elective surgery. With public reporting the informed consent of patients acknowledging that they are embarking in increased risk because of their weight is not really helpful. Rates of wound complications, readmissions to the hospital, recurrence of hernias will be tracked for individual surgeons.

Fortunately, at MMC we have a Metabolic Medicine and Weight Control Center for patients in need of assistance with weight loss. Lets no take the blame for preventable complications.