Unlike other medical specialties, surgeons have had a very long-standing tradition of evaluating and maintaining quality by assessing patient outcomes. This tradition may be traced back to Ernest A. Codman who was a surgeon at the Massachusetts General Hospital in the early 1890s [1]. Although he was a founder of the American College of Surgeons, his peers ostracized him for his interest in using surgical outcomes to improve surgical care. Thankfully, his tradition has been maintained to this day, and is perhaps best known to surgeons of all disciplines through the unquestioned prevalence of regularly held morbidity and mortality rounds. However, the use of outcomes to guide quality assessment has rightfully gained popularity throughout medicine, and this drive for assessment and accountability has in fact been coined the ‘3rd revolution in medical care’ by Dr A. Relman [2]. The dimensions through which outcomes have been measured have exploded over recent years. From the traditional limited assessment of patient survival and morbidity, there has been a widening of perspectives to commonly include patient-centered outcomes (e.g. health-related quality of life, pain, and functional outcomes such as the 6-minute walk) and societal-based outcomes (e.g. length of stay, cost-effectiveness).

However, from an even broader perspective, it is probably simplistic to believe that patient outcomes in isolation are sufficient to define quality of care. To this effect, Donabedian proposed a paradigm that recognizes three components in the assessment of quality of care: structure, process, and outcome [3].

- **Structure** includes the physical setting of the hospital or clinic, as well as the credentials of the health professionals, e.g. number of nurses or respirators on a given ward or unit.
- **Process** is a more complex notion that encompasses how services are provided to the patients as they move through the health care system.
- **Outcomes** remain the component of Donabedian’s paradigm that is best known to clinicians. In surgery, this has typically been highlighted by the presence of a normally healing wound, and the answer to that most complex of questions – ‘how are you doing?’.

The evaluation of the first two of these had until recently formed the basis of many traditional hospital accreditation processes, and examples are highlighted in Dr Langer’s paper in this issue.

A modern view of the relationship between outcomes and quality of care may perhaps best be rendered by the following statement: ‘outcomes are cues that prompt and motivate the assessment of process and structure in a search for causes that can be remedied’ [4]. In this issue of HPB, we have brought together a number of our colleagues with specific interests and expertise in HBP quality evaluation. Their experience comes from many countries with widely varying systems of health care, and is related to their roles as regional health officers, scientists, and leading clinicians in HBP. They each bring their own complementary approach to the overall goal of improving quality in surgery.

**References**