Panel 4 (Closing Panel)

Moderated By David Flum - Closing Comments

The Future of Surgical Quality—From Micro to Macro

Would You Rather Be Maitre’d (and Set the Table), Or Be King For a Day?

Participants
Dale Bratzler, DO, MPH
Samuel R.G. Finlayson, MD
Donald E. Fry, MD
R. Scott Jones, MD
Frank R. Lewis, Jr., MD
Michael Pine, MD
Thomas R. Russell, MD
John J. Seidenfeld, MD
Steven R. Vallance, MD

David Flum, MD: Thanks to everybody for staying. This last session was always envisioned by Dr. Polk, if I could get in his brain for a moment, as one of the sort of the real purposes of getting together. This meeting focuses on multiple different levels. It is a discussion and a roundtable intended to vigorously debate and to nettle each other about getting beyond words, but it’s also an attempt to set an agenda. Although the audience here is really part of the participation group, the real audience is intended to be through Mr. Kevin Horty and General Surgery News and the American Surgeon through Dr. David Richardson. We will speak to agenda-setters and policy positions at CMS through Tom Grissom, and through the American College of Surgeons and the American Board of Surgery and through the VA. It is intended to set the agenda for the next five years of discussion regarding quality in an organized way, by pulling people together from all different sides and all different stakeholders.

There is a fantastic book called From Good to Great,1 which describes how companies survive generational change and how they really take themselves to the next level. One of the key components of all those organizations is that they find a driver who has a set of core values who brings people on the bus. Those people all are not headed in the same direction, necessarily, but he brings talent on the bus. Dr. Polk has many qualities, and I understand it includes driving a bus. He surely knows how to get the right people on the bus, and you see that there is a whole different set of people here from all different spectrums who need to be represented in this debate.

You have already heard my thoughts about where I think the agenda needs to be set. What I am asking now is that each of you spend between three and five minutes and help us set the agenda, and help us leave here with a very clear sense, an organized sense of what should be done next and what can be done next and where the resources should be spent next.

I will set a couple of ground rules so that we’re not all pie in the sky here. Let’s avoid: a) We need more research; b) we need to think more about this or, c) meet again. Where should we focus the priorities for the next five years in American surgery to improve the quality of care?

That will leave plenty of time, after we move through three to five minutes, to hear people like Dr. Khuri, Dr. Goldfarb, Dr. Polk, and others in this crowd who have strong feelings about where the agenda needs to be set.

The goal is to leave here with an agenda, a helpful way to prioritize the Board of Surgery, the College of Surgeons; maybe it should be JCAHO or CMS, to help set the agenda for the next five years and moderate the debate.

If you had all the money in the world, what would you do? Let’s take money out of it for a moment. In other words, if you had access to power, what would you do? That’s the way I’d like to set the agenda.

Now, you’ve heard where I think the agenda needs to go. I’ll highlight that in two minutes later on, but why don’t we start at the end and move straight through to the other end of the table, and then we’ll hear from the audience.

John Seidenfeld, MD: Over the past two days, we have heard some excellent talks, and Dr. Goldfarb has certainly shown us a way that we can raise the bar. I don’t think anybody would say that the level of care in this country is poor. I think our level of care is good, but that said, I think it can always be better, and a number of people have talked about ways to make it better. We’ve heard about modeling and about looking at the process and process engineering. There have been a lot of very good ideas here. The whole idea of going toward Six Sigma and raising the bar is something that all of us hopefully can get behind. That’s number one.

Dr. Flum: Let me interrupt you for a second. For the sake of this panel and because I’m going to be an aggressive moderator and aim for a real agenda—not platitudes and not words, Six Sigma is what we all agree on. Where do you think we need to spend our priorities to get there?

Dr. Seidenfeld: Once again, Dr. Goldfarb showed us, and

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the modeling has shown us, and the process engineering has shown us that we cannot afford to have “one 747 drop out of the sky each day,” which is what IOM alleges is happening in this country today. So we ought to set a real agenda for percentage-lowering of the number of preventable deaths either due to elective surgery that shouldn’t have been done or due to surgical infection or due to some process within an adverse event that we could reengineer and improve.

We are far away from Six Sigma, but we certainly could start putting realistic percentage goals into our agenda. Payers need to reward those people who are doing things to lower their mortality rate, and who are bringing NSQIP or SCIP into the market. Any way that we can improve the process should be rewarded.

Dr. Flum: Dr. Seidenfeld, would you recommend payors only pay for major surgery in hospitals that have a process like NSQIP?

Dr. Seidenfeld: Never, and that’s because I live in a world of choice. As has been said a number of times, we’ve got to raise the bar in the whole community. This is not just about one or two hospitals in one state doing something well. This is about everybody within the health care system improving the processes which they use and getting the few, the small percentage of “bad actors,” out of the mix.

We really have to look at trying to improve the whole system. Dr. Flum, you really have not gotten to the point of this “cottage industry” that most people are involved in today. We must get surgeons working together, because the FTC has said you can come together for quality projects, you can negotiate with health plans for pay for performance even if you are not related in your practice. Surgeons are not doing that, for the most part.

We really have to address how are we going to start to bring, not the universities that have 200 people already on faculty, but the ones and twos in every metropolitan city across this country who are the folks who are doing most of the surgery. How are we going to get them paired together and working on the northeast part of Louisville or the southwest part of Louisville to raise the bar in each of those areas?

Dr. Flum: Great. So if I were going to summarize that, because I think it’s important that we leave here with a very clear agenda, it sounds like you’re saying we need to use the power of the payer to mobilize local communities. Is that correct?

Dr. Seidenfeld: I think we all have to work together to improve the care in our communities, and we certainly stand ready to do that.

Dr. Flum: Thank you very much for the comments. We’ll be able to debate those later.

Dr. Bratzler, I asked you before, if you had all the money in the world, what would you be tracking? You’ve helped us track, in American surgery, more than anybody, process of care. What would be next for you?

Dale Bratzler, MD: I have three points I want to make. I have actually been thinking about that question most of the morning now. The first one doesn’t involve money. I love coming to meetings like this where I am in a room full of motivated surgeons—highly motivated, truly on board, and really wanting to focus on improving the quality of surgical care in the United States. Now, tomorrow or the next day I’m going to fly off to another state and give a talk, and I don’t always find quite the commitment to quality or agreement with that somebody should be measuring care.

So I would say once again, this is the group of leaders in the room that I think can help drive this, but I think we need to come to some initial menu of performance measures. They won’t be perfect. They won’t be the best ones at first. Whether they are outcomes, process, or a combination of both, we should pick the low-hanging fruit.

Once we come to agreement (and maybe SCIP’s not the right one, and we are open to hear comments and ideas for other measures) and once we have this menu of measures that with which there is general agreement, then we—and you, as leaders—have to get surgeons all over the country on board to support those and recognize that we all need to focus on improving quality.

CMS keeps bringing back to us the fact that the pace of improvement is too slow, even when we have measures where there seems to be general agreement. We have been focusing on acute myocardial infarction care for years and years and years, and we still haven’t gotten to full compliance with some fairly simple performance measures. So the pace is too slow. We must get everybody on board to the low-hanging fruit. So coming up with the initial set of measures and getting everybody on board to work on some common set of measures that everyone can focus on.

The second thing that must come out of some of this work is that we do not have that unlimited pot of money. One way to get a whole bunch of it is to start addressing the items that you raised on the first day, David, and that is the marked variations in utilization that occurs across the country.

You know, Elliott Fisher and his group just released the updated Dartmouth Atlas this past week and once again showed there was this 30% variation. If you look at the Dartmouth Atlas Web site, it alleges that 30 percent of care in the United States is unnecessary. We absolutely have to figure out how to start addressing substantial differences in utilization. We may not know the exact rate, but I think that it probably doesn’t need to vary as much as it does.

That’s a place where we can really start finding money to start doing some real performance improvement, start reducing inappropriate utilization where it is really inappropriate. I don’t know how to define that, but we’re going to have to tackle that problem at some time, inappropriate utilization.

Lastly, my pie in the sky is in lots of information technology. I loved the presentation that Dr. Fry gave about different ways to use administrative data sets. But I frankly would love to see information technology built so we had integrated electronic records where data are captured at the point of care; it’s not retrospective, or an afterthought. As you provide care to the patient, the data are captured; it’s into the system somehow. The VA’s close, but they’re not perfect. Capturing
data that would allow us to collect and report a host of process and outcome measures, far more than we have now without the high-dollar resources that we have put into retrospective chart collection, and do it now. The data are adequately risk-adjusted, because we have all the clinical data that Dr. Fry noted at the point of care, you have it in the data set so that we could automatically record that. That would actually provide decision support and would actually help drive care and to help make decision-making better.

One of the things we heard from Dr. Goldfarb was about the hostile abdomen index—real-time risk assessment that right up front would help the surgeon make decisions about care. I mean true real-time decision support, perhaps linked with a screen in the operating room where you could get that consultation in a hurry.

**Dr. Flum:** Great, Dr. Bratzler, I appreciate it. So this is what we call focused qualitative research. I’m developing themes as you speak, so we don’t really need to repeat them. So if you’ve already come up with these themes, you’re stuck. The person at the end, Dr. Vallance, you are really going to be on your own trying to come up with a new one. If I was going to synthesize the two themes that just came out, number one is that we feel the payer has a role in setting the agenda, we need physician buy-in, and that we need a set of metrics that would be appropriate, maybe an expanded SCIP version. The second theme is this idea that an investment integrated in information technology to create a lot of the risk adjustment and point of care management and decision support could be facilitated.

Those are two themes that clearly are on the agenda of this panel. Dr. Russell, you are in an estimable position right now because you run one of these big organizations that has a lot of influence. Where would you go with this? What’s on your agenda, your next step, not the whole list of ten?

**Thomas Russell, MD:** It’s very important to keep short-term goals in mind and then also have long-term goals, and it’s very important that you focus on things where you can make a difference. We’re not going to get a huge amount of reimbursement increase for surgeons. Let us say that’s not going to happen; we are not going to create immediate change in the tort system. That’s just not going to happen in the foreseeable future.

Where we can make a difference is in safety and quality. We need to work diligently on most of the projects we’ve started at the College. We’re in the early innings of this game. We need to develop best practices and process as we move into value-based purchasing. We clearly need a way to evaluate those best practices and processes, because I do think that we will be going to that sort of a payment system in the future.

We need to educate the health care providers, the surgeons as well as the other people on the team, but need to participate with the nurses and the nurse technologists. We need to form our educational programs around the six core competencies. We need to continue to relate to a data collection vehicle, such as the self-reporting, so that surgeons know what they’re doing. This will relate, as I mentioned earlier, to their credentialing and privileging in a hospital.

We are very sanguine and very supportive of NSQIP and SCIP. The College needs to get more involved as these things evolve, and we need to go into further iterations and maturations in development of these programs.

We need to set standards of care so that hospitals and institutions can get “tickets,” which are going to be very important in the future. You’re not going to be able to do operations without those tickets; neither the surgeon nor the institution.

We are now accrediting cancer centers, trauma centers, bariatics. We are going to consider breast centers, of which there are many. We’re looking seriously at office-based facilities in this country that are often not accredited.

Finally, we need to work diligently with all other interested medical entities, like the AMA. We’re such a fragmented industry at this point that we need to work together with all parties interested, and so we need to be at the table every time NQF, NCQA, AQA, SQA, all meet. That is our short-term goal.

**Dr. Flum:** That’s a fantastic agenda, and we are excited to be members of the College of Surgeons as a result.

**Dr. Russell:** We’re happy to have you as a member, David.

**Dr. Flum:** After the last 48 hours, I’m surprised.

(Laughter.)

**Dr. Russell:** As long as you get off that guild issue.

**Dr. Flum:** I told him before that I had taken the role of being a thorn in his side. If I could distill what really the agenda items that represents a change is this concept of accreditation and the College’s push towards using accreditation as a tool for quality. I’ll come back to that in my comments a bit later.

**Scott Jones, MD:** Well, I’m sitting next to Tom, and obviously there’s a certain amount of collusion going on here, because we have been talking about almost nothing but this particular agenda for the last four years, so this is a great opportunity. He’s hit on some of the things, but one thing that we’re working on already, and have been is absolutely essential: buy-in for every surgeon in the United States to these issues of promoting quality and safety, because that’s what it’s going to take at the end of the day. The surgeons in every hospital must take the leadership in their operating room to do the things—the surgical time-out, the briefing, the debriefing, and to provide leadership for the nursing and all the other people involved in the patient’s care, particularly in the operating room. That’s something that the College has been doing, and we are going to continue to do. We’ll go anywhere anytime and talk to anybody about this, and we’re going to continue.

There are some here-and-now things. We are going to have to make a decision about a patient safety organization, the legislation that has just been passed, for which AHRQ is working on the regulations. The American College of Surgeons will be front and center in developing a way to use those resources or those laws to collect data on near misses and adverse events. We prefer to do that in partnership with others, preferably with other surgical nursing and anesthesia organizations.

The next thing on my list is that I want to take Dr. Goldfarb’s list and put it in an organized format and distribute it to every
surgical service in the country. You can lead a horse to water, but you can't make him drink. Then we will just send them another copy and another copy and another copy. The point is:

We have to get some local operational items in place in every hospital, and we want to work with Dr. Goldfarb.

Now, Tom talked briefly about the numerous centers. We have some work to do on those to bring them into a sharper focus. Going through the bariatric center exercise helped me to understand the essential ingredients. Now, I think we need to take those programs and use those same principles, not necessarily to have a comprehensive center like trauma. We can't have geriatric centers because 80 percent of the patients are over age 60 or 65, but we can take the center principle and develop standards of care that are unique for the geriatric patients and put them in place in every hospital and expect standards like a center. We need to bottle up the center concept and use it in places other than the centers.

We need more partnership with the insurance industry. I think we're at a point where we have to work together with the health insurance industry, and the program that's happening in Michigan today has got our profession, the hospital industry the health insurance industry working together on something besides fighting over money. They are working together to improve quality, and we need to expand that concept from coast to coast and border to border.

We need to have people who understand safety and quality, and we need special educational programs, and we're beginning, on the first of July, to develop safety fellowships.

Dr. Flum, you have an advanced degree in the research outcomes clinical research, which enables you to do those things like nobody else does it. We need to have people trained in the fundamentals of biostatistics, epidemiology, behavioral situation awareness, communication, and those kinds of things to have a cadre of young people who can lead this safety effort for now and forever more. We also need to collaborate with the AMA, AQA, and anybody else who has issues on the table. We're doing that now. Tom is on the executive committee of the AQA. I'm on the executive committee of the AMA Physician Consortium, and we are going to get this agenda on the move.

I want to go back to this OR observation situation that was presented earlier today. I think we all understand that the OR is a place where we need to focus. We need to study those systems systematically, and we need to study it so that we can make observations that are generalizable to every operating room.

Operating rooms are like snowflakes—there are no two that are alike, but all snowflakes are cold, right? So there are some common things that we can work on to take the pilot's checklist and see how the operation and operating room really works. I think having scholars and systems engineers can do that in a program organized in the College. Groups like AHRQ and partners in industry could provide help. Dr. Russell's concept emphasizing quality and safety, and training and education is important.

Dr. Flum: Let me have my two minutes. Where I think we need to focus is in two areas: One is leveraging these accreditation programs that bring a truly novel component, which is the good faith of the American College of Surgeons. The College of Surgeons is respected, viewed as nonpartisan, but as a nonadvocate, frankly, for quality. I really do. It brings the talent of the College of Surgeons together with a group like CMS, which does not have any of those things. It doesn't have the knowledge or the objectivity, nor is it an advocate, necessarily, for quality. Really it's a payer, and it's viewed as a payer that wants to be a smart payer, a smart purchaser of healthcare.

By the CMS or groups like CMS linking up with accreditation programs, it's the best of both worlds. The CMS can say, "Listen, we're going to allow you to pick what the appropriate quality agenda is. We're only going to pay for procedures done at hospitals that meet those standards. If you think those standards should be set based on the surgeon level, we'll buy it. If you think it should be based on the system level, we'll buy it. If you think it should be based on the use of guidelines, maybe even Dr. Goldfarb's measures, you decide, we'll pay for it." That's enlightened purchasing, and it does not lead to the conflicts of the government buying healthcare.

I would focus on, in the next five years, linking the payer, the effector, with the group that sets the quality agenda.

The second area is in the big pool of resources that the College of Surgeons and others have for quality. I would make monitoring outcomes, something like the NSQIP program, part of the picture, not just tracking outcomes, but also an effector arm that deals with all the process of care issues we have discussed.

Right now if you envision the pool of resources, my vision of it being spent on tracking outcome data. I would focus the pool so the priority was less on the outcomes and much more on process. That's what we are all saying, but as a concrete agenda, I would make it two-thirds of the pool rather than what it's probably now, which is only five percent of the pool.

Those are my two agenda items, and the themes that need to be developed here.

Donald Fry, MD: I think quality in hospitals, like politics, is a local issue, and I think we can dance around AHRQ and all of the rest of them, but I think that will be a mistake. We do not need a whole lot more research because we cannot enforce what we already have. If I have learned nothing from my frustration, which is boiling over right now, in the SIP project is there's enough literature to fill this room with individual manuscripts showing how preventive antibiotics ought to be used in surgery, that having been triggered by our esteemed leader here, and we still can't get it right. Despite having SIP and all of the collaboratives that Dale and I have worked very hard in, what he did not present is what happens if you stop the pressure on the institution, because it all slips back into the same old trashy behavior. Not only do we fail to implement what is well known, we do not sustain the gains.

So there's a wonderful paper written by Shapiro, 20 years ago. It's probably time to be implemented, showing that if you put a rigid protocol in the hospital, you reduce infection rates and you also reduce antibiotic utilization: Cost conservation...
goes with improved care. In the orthopedic cohort, 80 percent reduction in antibiotic days, 80 percent reduction in surgical site infection. This is not rocket science.

The SCIP group has done a great job in formulating things that should be implemented. We must go to protocols. I’m tired of the democracy because the democracy in healthcare, really represents however many thousand CEOs that are practicing medicine in each hospital. A more rigid approach to protocols of the things that we know to be correct would have an immediate and a positive effect.

Dr. Flum: Who enforces them?

Dr. Fry: Hospitals have an enormous responsibility right now to enforce them, and perhaps that needs to be the best way, through their trustees as well as the medical staff be on board, as the medical staffs have been in the SIP project.

Dr. Flum: Should the College of Surgeons set the protocols and say, “This is the standard of care,” like ACOG?

Dr. Fry: I’m not sure how good even the gynecology thing has worked when it’s done at a national level. By my last check, obstetrics still had the highest malpractice rates of anybody in the country. So the obstetricians and the anesthesiologists, are not really parallel tracks at all.

The issue needs to be more of a local enforcement. It’s great to have national movement and national direction and bring public and professional attention to safety as Job One, to sort of steal a line from a not-so-successful automobile manufacturer. (Laughter.) But the point of it is that this has to be a grassroots initiative at our hospitals. We need a champion within each institution to align the incentives of the hospital and the physicians into a common direction.

Dr. Flum: Dr. Fry, if the goal here is setting the agenda, expecting a grassroots movement sounds like a recipe for 15 years later.

Dr. Fry: No, it’s something we can start doing next week. For example, score cards for the hospital in our performance and monitoring our activities are very, very important. The physicians are getting beat on now about wanting to have outcomes reported, but actually economic outcomes, not quality and safety outcomes. Having a scorecard to say what has been our infection rates. Having it posted publicly as an organizational outcome. You know, I’m still inspired by Peter Cruse and Harlan Stone did the same thing at Grady. He did a concurrent study to find out what wound infection was in his trauma patients. He said, “Oh my God, this was terrible.” So he instituted a study and immediately every thing decreased by 50 percent by just posting numbers and telling doctors and nurses what you were doing.

There needs to be more transparency locally in having reasonably concurrent outcome data to try to inspire people to do better. Physicians and nurses and hospital personnel will respond to the challenge immediately if we can have the number of days since there was a last retained sponge, the number of days since somebody fell out of bed on ward six south, the number of days since there were these kinds of adverse events.

Dr. Flum: How do you make this happen, Dr. Fry? It sounds like pie in the sky.

Dr. Fry: First of all, it’s just a matter of whether you want it or not. Is safety really something that is an inspiration to you or is it something we can go to conferences and talk about?

Dr. Flum: It’s obviously not. You see what’s happened leading into a grassroots movement for most people. They ignore it.

Dr. Fry: I don’t think the grassroots movement has felt the urgency of what needs to be done. So I appreciate your adversarialness, and I think it’s wonderful. Our experience with the SIP project for Dale and I has been a tremendous enlightening affair that just presenting the information and trying to stimulate people to align them with the known information is not working. It isn’t working as fast as it should be, and there is already evidence of erosion if you don’t keep the pressure on.

We need more protocols and medical staff in the hospitals to support them. If we could get more buy-in immediately at the grassroots level, we can get more impact, and then we can have our larger organizations carry forward larger agendas at the more macro level to move us through the very troubled waters ahead, because the waters ahead are really troubled.

One has talked in this whole conference about workforce issues with spiraling population and aging people and declining numbers of surgeons and earlier retirements and all of that, and how is that going to factor into safety when the demand goes up and the number of nurses and physicians and healthcare providers in the aggregate are not going to be adequate?

We have big agendas that Dr. Russell and Dr. Jones need to be focusing on about where is this going, but we immediately need a grassroots level to inspire institutions to be responsible for themselves and to go forward and do what we should be doing!

Dr. Flum: Great. One of the reasons I was interrupting is so I could really have it crystallized. You want a grassroots movement to make this thing happen, and we’ll deal with the issue of how to make it happen as part of a future agenda.

Dr. Flum: Sam, you’ve been looking at this from a researcher and also a practicing surgeon perspective. Where do you want to take it?

Samuel Finlayson, MD: Well, I agree with a lot of what Dr. Fry said. In fact, I began to suspect him of looking at my notes. (Laughter.)

Dr. Flum: He sounds like he came into this a little loaded.

Michael Pine, MD: Now you know how he got through medical school. (Laughter.)

Dr. Finlayson: I was going to say something very similar, but perhaps not with his great passion. One of our problems is that in this whole quality effort we’re out of balance in terms of quality assessment and quality improvement, which are very different. We’ve been spending a lot of time talking about assessing outcomes, transparency of outcomes, when we really haven’t done nearly as much on the side of improvement. An example of that imbalance is NSQIP. I hate to harp on NSQIP again because I like NSQIP in a lot of respects, and I think it’s a horse we can all ride. I hope Dr. Polk likes that.

It’s mostly about collecting information about outcomes and then relying on magic to make the improvements come about.
As a major theme I would say we need to shift more away from spending so much effort and energy and resources on assessing outcomes and spend more time looking at how to make things better where practice is actually happening.

The second theme would be that if you want people to do things the right way, what you need to measure is whether they’re doing things the right way. If you just measure what the outcomes are, it doesn’t give any insight as to what they need to do. A lot of our outcomes assessment to this point has been mortality, morbidity, things like that, but you report that back to somebody, it gives you very little insight as to what you specifically need to do about it.

There needs to be a shift toward measuring outcomes in terms of compliance with the right thing to do. We’re getting toward that in some respects in that you see some of these reports on the Web. It’s not only about mortality and morbidity, but now we’re seeing reports about compliance with specific practices. When a hospital knows that their compliance is low, they know immediately what to do and they go and increase their compliance.

Thirdly, I agree with what’s been said, we could fill this room with the amount of data that supports the specific practice of care, or practices, but we still have a problem with people not knowing what to do. I’m not so cynical that I think surgeons are intentionally providing bad care. I think that most surgeons are doing their best to take good care of their patients and abide by good practices. It’s still a problem of people not knowing what to do.

Being from Dartmouth, I’m very much immersed in this idea of practice variation, and it’s a problem. And, you know, the one thing you can say when you see practice variation is that somebody’s doing it wrong. If you’ve got substantial variation, you immediately know that something’s wrong.

As a final point, we need a greater effort to establish the kind of culture that anesthesia, for example, has established, where there are very explicit guidelines. The Cochrane Collaboration are wonderful efforts to try to consolidate the best evidence that we have and give us specific ideas. I don’t see a lot of activity in the Cochrane Collaboration from surgeons. I think that that would be a good move to make.

Dr. Flum: Sam, are you also talking about the issue of utilization of care and the 30 percent that’s been bandied about as being inappropriate care. Do you think that’s a major issue that needs to be tackled?

Dr. Finlayson: That’s part of it. I’m not going to try to separate appropriateness of care with inappropriate treatments.

Dr. Flum: So that’s really not a focus right now?

Dr. Finlayson: Part of treatment is knowing when to give it and when not to. You know, I see, for example, variation in rates of laparoscopic Nissen fundoplication over time as a failure, because what we’re seeing is it varying over time and varying, you know, eightfold across geographic regions. We know that people are working up and treating that disease in very different ways.

Dr. Flum: It’s just a version of variation. It is an area that, in the variation movement, has not really been the focus of the College, for example, the question of inappropriate utilization of cholecystectomy, or we haven’t addressed that 30 percent variation issue. As we’re developing unique themes, clearly we’ve talked about shifting resources within NSQIP to quality improvement. That theme of regional variation, be it in what we do or whether or not we do it is an area to focus on.

Dr. Finlayson: Reframing outcomes in terms of compliance with specific practices rather than mortality is song that I sing and it just keeps coming back. You can’t differentiate between hospitals and between surgeons with mortality for the vast majority of the things that we do. Mortality is not a good way to compare the hospitals. On the other hand, compliance with guidelines, we know what the standard is, it’s supposed to be 100 percent or something very close to that, and if we’re achieving that, then you can say that, you know, good outcomes should follow. The one last thing I was going to say is that I really do believe that the ACS should take the lead on this in terms of developing a set of guidelines and a culture of following guidelines, because the ACS has the credibility to pull it off, and that most surgeons believe that the ACS is behind them and thinking of their best interest.

Dr. Jones: We’re taking names. (Laughter.)

Dr. Flum: Dr. Lewis, I’ve had a wonderful chance to chat with you about the power of the American Board of Surgery and what might its agenda be in setting the quality agenda. Where are you headed with that? Where do you think we need to go in the next five years?

Frank Lewis, MD: Well, I’d like to talk generally if I could about your basic question here for the panel. The first thing I would do is pick the big targets that issues and are likely to yield major changes in reasonably short order if you deal with them effectively. The disparities in rate of operations and utilization of resources around the country have been highlighted in multiple areas and to me are a huge target; I would make that focus number one.

Widespread use of practice guidelines can be arrived at fairly easily since these are already done in multiple areas and have the greatest potential to make change quickly; that is number two.

Number three would be approaching the individual practitioner and the local hospital with mandated outcomes data collection that profile individual surgeons’ results. From that you can identify improved practices and individual outlier behavior that needs to be corrected. Those are the three levels I would deal with in terms of major targets.

Dr. Flum: Let me make sure I got them. It’s variations in how we use surgery, variations in how we do surgery, and then variations in how systems correct surgery.

Dr. Frank Lewis: Variations in surgery and the resolution of that, guidelines for practices, which I would charge specialty societies to do, under the umbrella of groups like the College, and outcomes measurement at the local level.

Now, I would raise two things that nobody has mentioned all day but these are the places I would spend the money you asked about, because these are two underlying issues that are huge. They’re expensive, but would make such an immense
difference in quality of care that I think we should try to find a way to fund them. The first is universal implementation of the electronic data record, and the second is universal implementation of digital imaging.

Those two things alone would save so much redundant time and effort in hospitals and allow data collection to proceed so much more easily that they would pay for themselves in a few years. I recognize that they are enormously expensive, and probably the federal government is the only entity that has the money to fund them. Even if it required bond issue and payback or a government funding program for hospitals, I believe that we have not focused on that as being an essential item that underlies everything we do. The cost of collecting data in the hospitals is a major red herring that’s been raised. People talk about the cost of NSQIP, which is approximately $100,000 per year per hospital. Considering this to be too expensive is utter nonsense, comparatively.

I just had a recent experience with this. A close relative of mine had back surgery at a hospital in Pennsylvania two weeks ago. She was in the hospital for four days and had uncomplicated surgery on her lumbar spine, which took three hours. She did not go to the ICU and had no problems in recovery. The bill for that was $40,000.

Now, if you can spend $40,000 on one person in four days in an uncomplicated hospitalization, talking about $400,000 a year for a hospital with 300 beds is nonsense. We’re talking about decimal dust. (Laughter.) We really need to put in place outcome data collection for all inpatient surgery.

Finally, the biggest issue relates to the leading question I asked from the floor yesterday, because I view that as the critical link in the whole thing. I asked “Who is going to be the effector? What are the motivators?” Nobody answered that question.

Dr. Flum: I would say payer. That’s what I really think.

Dr. Frank Lewis: Well, I think there are multiple motivators, but no one here has talked about the importance of that and the recognition that the reason the VA system works is that there’s a structure and a hierarchy for making change. There’s a group that did the measurements and the same group is responsible for management and putting results in place.

The reason it has not happened in the rest of the healthcare sector is because we don’t have any overall structure or hierarchy in the healthcare system. So the question is: Who else could be the motivator? Now, laudatory as Dr. Polk and his effort in Kentucky is, and Dr. Goldfarb in his hospital, they are not the answer.

Relying on champions in a given situation is wonderful, and it’s great to see that kind of initiative, but we’ve got 4,000 hospitals, and you’re not going to have that many champions. We therefore have to do it another way. There has to be an intrinsic motivator, and it seems to me that’s where we have to turn principally to the insurers, because they get people’s attention. If you attach dollars to it, you get people’s attention. There are multiple ways you can tie dollars to these kinds of quality initiatives. You can do it in a negative way and you can do it in a positive way. But I think you have to do that in some way.

The JCAHO can play a major role because they, in fact, have requirements for hospitals that have not been focused adequately on developing quality and safety standards in surgery. The people in hospitals who are responsible for accreditation expend an enormous amount of energy on nonsense activity generating paper, as opposed to highly effective monitoring and things that would work. (Applause)

The Colleges’ intent to accredit various kinds of specialized centers of excellence would be another motivator. I think we need to look to the possible motivators that one could arrive at.

Dr. Flum: Would you add the Board as well?

Dr. Frank Lewis: The Board is only a motivator for individuals. It has no responsibility for institutions. We would certainly be glad to do our part, but we have a very limited role, because we only deal with individuals and their certification. We have no ability to accredit a hospital or to control their actions. The insurers are a much bigger influence because they control the dollars.

If we had a global plan for moving quality forward, and we went to the insurers and said this, I believe we could develop partnerships, much as Scott has talked about, because it’s in everybody’s best interest to do this. I’m not so certain that we’re going to find 30 percent decreased costs in this, because offsetting the 30 percent overutilization is an equal amount of underutilization. It’s not entirely clear that if you corrected the healthcare system that you’re really going to reduce the costs overall via utilization. On the other hand, you will reduce cost significantly by improving outcomes, because it is very expensive to take care of bad results and complications.

Dr. Flum: Dr. Lewis, I just want to make sure I can distill this nicely. You think the effector arm can be, it sounds like, insurance companies and accreditation agencies. They need to be the effector arm.

Dr. Pine: As a midlife MBA who spent the past 20 years measuring and trying to improve quality, I have two thoughts. The first one is: Follow the money. You started to follow the money, but you didn’t follow it all the way. Insurers are middlemen. They don’t pay for anything. They basically take their cut between the people who ultimately pay for this stuff and the people who ultimately deliver it.

In the great American way, middlemen and middlewomen are very important. Ford buys tires for $2, we buy them for $80 because it’s got to be split 100 times. It’s a genuine service. But the people who play this game are the people who pay for this game. What’s the return on investment on quality? Brent James put it best “Well, we spend some money on quality in our healthcare system and we get a tenfold return and we don’t see a dime of it. It disappears somewhere.” I would contend there is hardly anywhere in the health system a return on investment in quality. What are you doing right now? You’re fighting with CMS because they’re going to cut you five percent, so you want the money back, and you’ll continue to play this game. IOM said something that hasn’t been quoted, except once, that the whole payment system is toxic, and toxic payment systems get you just what you’re paying for, a toxic healthcare system. Dr. Polk will tell you how many people are
running up to fund his very, very successful quality program.

The big drivers are the payers, and you’ve got to reinvent the reimbursement system to get the incentives, if not correct, at least nontoxic. We’re paying for all the wrong things. You pay for volume and you’re going to get variation, if you pay uncritically for volume. If you pay for high-tech, you’re going to get high-tech. If you, in essence, keep cutting the cost of an office visit, what do you do when you can’t raise the price? In the auto business, you start stripping it down, and the car then becomes less and less and less. The education goes, the prevention goes, all the things we say are important goes.

Dr. Flum: Dr. Pine, your agenda is to change the healthcare reimbursement system?

Dr. Pine: To change that, and you’ve got to be at the table, because that’s going to get changed. Mr. Grisom said as much yesterday.

The second piece, and this can be a bit of controversy, particularly with surgeons, is measuring process as a production function. It’s real important for you. People buy outcomes and they buy benefit. So linking process and outcome is critically important. I tried to touch on some of the methods. We get variation grades, we get risk-adjusted outcomes, we get guidelines. Linking the outcomes that people buy to what you do, so you can do better and they can get better, is a critical piece. I don’t think we’ve done very much research in that area. They don’t care what you do, they care what they get. Two things.

Dr. Flum: You don’t believe in a nationalized healthcare system, do you?

Dr. Pine: I believe in a free market. I’m a free-market Democrat. There are two of us left. (Laughter.) Markets work great.

Dr. Flum: All right. Dr. Vallance.

Steven Vallance, MD: It truly is terrible going last. Let me just summarize maybe from my perspective: I looked around the conference table, I’m the only practicing community surgeon here, and that’s where most of what we’re talking about takes place. The problem is not with the people in this room. It’s really not, we all get it, and we’ve made the appropriate changes, and we know what we need to do. As I think several people pointed out, there are people in my community and all small community hospitals, where most of what we talk about takes place, that want to do the right thing, and they think they are doing the right thing, and several reasons they don’t get it done. They don’t get it done because they think they are too busy. They don’t get it because they don’t take the time to pay attention to it, or maybe they don’t get it because they’re not as good as we all think they are, or they need some help.

So I go back to what Dr. Polk has always said. It’s another baseball analogy. You gotta throw yourself a pitch you can hit. If you looked at the results last night in the Boston/New York series, Josh Beckett pitches for Boston and the Yankees can never hit him because he has a fastball and all these change-ups. Well, they beat him to death last night because he threw nothing but fastballs. Well, that’s what we need to throw ourselves. We need to throw ourselves a fastball straight down the middle, a pitch that we can hit. Every Major League baseball player can hit a fastball 70 percent of the time.

How do we do that? And with all respect to the gentlemen from the College, Dr. Jones and Dr. Russell, as a community representative, the way we do it is what we’ve all talked about here. It has to be a grassroots effort. No matter what you guys tell us, unless somebody out there is actually doing it, it’s not going to make any difference. Again, those of us in the room are going to do it, but are the people that make a difference going to do it? We have to incorporate several aspects. There has to be a carrot somewhere. We learned that in QSS. We had a physician champion at every hospital in which QSS was involved and somebody who bought in to the system. Maybe in a small hospital that’s one surgeon, maybe in larger hospital it’s two or three surgeons. But they’re not the people that you need to change, because they are going to buy into it anyway. You must change all the other colleagues on the staff. You have to do it a hospital at a time. Like Dr. Fry said, it’s local.

I think where the American College of Surgeons comes in—we’re all part of the American College of Surgeons, whether we’re a guild or a profession, you establish the guidelines. You do what we’ve all talked about. We have enough data. We know what the protocol should be. We had protocols developed in QSS. We may have not had every single piece of data, but the protocols worked. They were guidelines. We didn’t expect people to adhere to them 100 percent of the time, but we set our goal at 80 percent, and we strove to make that happen, and then pushed it to 90 percent and physician behavior changed.

Peer pressure, feedback, some monetary reward. There has to be a carrot, though, because people are going to get it for a little while and then they’re going to quit. That carrot has to be in the reimbursement system. So none of us are going to make a lot more money, but let’s do something radical: Pay the people who participate a little bit more. And it’s going to be a zero sum game. We all know that. So the people who don’t participate, don’t follow the protocols, don’t produce quality, pay them less. Guess what? They’ll either quit practicing medicine or they’ll change!

That’s what we need to do. Let’s have the people who know how to do it tell us what the protocol should be. What are the guidelines? What’s best practice of medicine for each individual procedure that we do? Perhaps start out with a small number, but let’s do it today, or let’s do it tomorrow. I don’t want to be back here in five years talking about the same things again and finding out that somebody else has made these decisions for us, but don’t really understand what the decision is supposed to be. It’s really going to be too late. So I would say let’s throw ourselves a pitch we can hit now, and let’s start playing ball now.

Dr. Flum: Dr. Polk, before I hand this back to you and to the audience, and we really do want to hear from the audience here, I just come back to the purpose of convening this group. This is intended to set an agenda. It’s intended to have some of the people in the room who can affect that agenda, some who aren’t here yet, but who will be reading this and be getting memos about this and having this emphasized to them when
they go back to their positions of power and their stakeholder interest.

I’ve been able to distill ten themes, and lay them out here so that we could understand, at least call them what they are. If you’ve noticed any other themes, please feel free to add to them. In qualitative research we develop themes until we can’t develop any more themes, then we stop developing themes.

There’s not universal agreement about these themes, but these are the themes that emerged. In no particular order, except the way that I was able to contain them:

1) Setting a standard for local hospital performance, essentially creating a grassroots movement, creating culture change, at the grassroots level, at the local level, saying that it is simply not reasonable to practice surgery at a local hospital without including a safety culture and a quality of care culture.

2) A shift in resources within NSQIP and within what the College is paying for, away from outcomes assessment as a definition of quality, and more towards a focus on process of care and quality, real performance, the things that work well for most patients, and focusing on understanding those things as both a way to track and improve the quality of care research.

3) Leveraging payers to accredited programs that are ongoing right now, as a way to link the effector arm and the arm that’s defining quality.

4) Effect that culture change that we were talking about through the enterprise of the College, training and education, in research in OR systems, in areas that have really not been the focus of either funded dollars to do research on what happens in the operating room. What Dr. Greenberg is doing, with a complete lack of ACS-funded initiatives or NIH-funded initiatives is to get in the operating room and figure out where the process is breaking down and what defines quality.

5) Universal NSQIP or something like it is improved and focused. It’s basically getting NSQIP and its quality improvement activities that we hope will come from something like NSQIP in every hospital in America and by leveraging with ARC and JCAHO and health insurance and other arms that can help pay for these activities.

6) The theme developed from the College is the idea of using accreditation as a leverage point, defining quality by bringing in the talent from SAGES and SSAT and the breast associations, to define through guidelines what quality is. That is distinct from the vital theme I talked about before of linking those accreditation centers to the effector arm of the payer.

7) Information technology, either the electronic medical record or digital imaging, integrating both, and by doing that, affecting risk adjustment in realtime, decision support and point of care, activities. That’s all related to information technology. It’s also something for which the surgical community has really been very much on the sidelines for, in many ways, and clearly something that is going to require a lot of resources.

8) Developing a unique set of measures that define quality, something as simple as that, getting the surgical infrastructure together to define quality with a common set of metrics. Maybe they’re super-SCIP, or the metrics that come out of the regions of Blue Cross and Blue Shield, RHIO. It’s going to be some common set of metrics to which we anchor quality and safety.

9) The last two themes had to do with really focusing on this issue of utilization. We didn’t say much about it, other than my opening slides. It has been the stepchild of this whole quality debate. Nobody has been willing to tackle appropriateness, and has been, and until we deal with it, we lose a lot of credibility. Raising that on our agenda is an important issue.

10) Dr. Pine, I hesitated on adding this issue of reimbursement because it seems like that’s a hard one to tackle. But having said that, if that’s one of the themes that all of this can’t be done without a rational purchasing payer system and a rational system for buying healthcare and paying doctors, then maybe that’s where we need to focus our energy first.

Those are ten unique themes that distill what has been talked about in the last 48 hours from this esteemed panel.

Hiram Polk, MD: Number one, we ought to start now. We’ve been at this idea for seven years. Surgery as a whole has not been working on this at all. It took us four months to get QSS started from nothing. We need to start the national effort now. We’re losing control of the process, or have lost it. The sooner we stop losing it, the better. People here who are the effectors, include major payers; all of our Council of Teaching Hospitals; our Colleges and Academics; Premier, one of our big hospital organizations represented; and TUV, which is a competitor with JCAHO, is represented. There are people here who can hear this message. The people are here who need to hear what we want to say.

We need to emulate anesthesiology. The one thing I got out of that, Dr. Russell, was how they built the constituency within ASA while they were doing these things, and I think we need to emulate that. I was very impressed when Bill Lanier outlined how they actually got that done. We need to reach the rank-and-file surgeons and make them feel good about the process. Getting the surgeons on board with this is really important. And, Dr. Russell, I know you can only put so many things in the Bulletin, but it seems like you might find a spot right after your introduction page to tell about what’s new in quality in surgery and let that message in any issue be the first message that comes out from the College.

We need more and more for all of you to accept the surgical time-out as a unique asset. It’s even better than what Alden has written in our syllabus. It is a wonderful time to collect concurrent data and to influence behavior, and we all need to get behind that. We have been pushed to do it because of wrong-site surgery, but it is a perfect mechanism to make a lot of these quality processes happen.

We need to get more surgeon involvement with NSQIP. Too much there you’ve got people collecting data and the surgical staff is too much at arm’s length from it. We need to get doctors involved in a front row sense.

We need to get more young surgeons working in health services research. The American Surgical Association, through some links that Scott and John Cameron built has
some newfound riches. We need to commit those resources to fewer PhD-oriented fellows and much more health services research people. We want to push people toward health services research over the next couple of years. That way there’s going to be behind you, David, Caprice, Sam, Selwyn and other fine young people who will come here and will make something like that work for the future.

We need to think about a “NSQIP light” or something simpler for smaller hospitals. It is too big and cumbersome for small hospitals and it will absolutely overwhelm them. You’ve got to give them small things; we’ve heard here about how much surgery is done in the smaller hospitals. It’s vitally important to let them help with quality and safety.

Dr. Russell, I seem to be talking to you and Scott more than others. You showed that wonderful booklet on patient safety. Are there any left at the College?

Dr. Russell: Sure.

Dr. Polk: Why don’t you see, by next Monday, if they could all be mailed to somebody? (Laughter.) You’ve got a great document there, and most fellows of the College haven’t seen it. You know, books that sit on shelves don’t help anybody, and you simply need to get those out, because it’s a good beginning.

I think the idea of forcing bariatric centers to make regular reports in order to remain accredited is really, really smart. That’s an incredibly smart long-term maneuver.

A point that’s very close to Dr. Jones’s heart, which he helped me understand, is some of the issues about inappropriate credentialing in hospitals in America. If someone has not done an esophagogastrctomy in 5 years, should they continue to be credentialled for that operation? It is a quality issue, and it links right back to what we’ve talked about.

We need to stop reinventing the wheel. We’ve got all the data and guidelines that anybody could ever want. As Dr. Fry said, this room would be overfilled if you took all those that are credible, sensible, and largely agreed upon. We need to quit refining that and go on with implementing quality processes.

Now, some specific comments: Number one, very interestingly, of the 32 people who died in SCIP 2004 in Kentucky, not a single one of them had an unindicated operation. So some of this discussion about inappropriate utilization, somebody in these proceedings needs to say, “There’s two sides to that coin. There’s inappropriate overutilization and there’s inappropriate underutilization.”

Dr. Flum: You also told us that a third of those gallbladder operations were done without stones.

Dr. Polk: But interestingly, they had the same good clinical outcomes and symptom relief as people who had stones. Maybe the country doctors know more than you and I do, or they have to see the people in the grocery store or church every week. There are several sides to the utilization issue, which I think is important.

The rapid improvement thing is really, really important, and the concept about realtime decision support bothers me greatly. In the 1970s, Carl Knutson wrote in Annals a point that was ridiculed by all of the senior people in our associations, who are now deceased, suggesting that surgeons sometime need to have a decision support device in their hospital, and it could have been done even then with a simple computer logic program.

Dr. Jones brought up particularly the idea that we need to reach out to everybody and get them on board. We need to find two or three leaders everywhere. The back marker, the horses that run last, are going to always run last. We aren’t going to fix those guys in the short term. They are naturally slow or lazy, and we even have a few of those guys in surgery. (Laughter.)

We need to let the leaders lead. You need the point that Drs. Fry and Vallance both made about find a few champions and let them go on and run. If you’ve got two or three or four leaders in a hospital, the others will follow. The competition makes them all follow.

We found out working in one hospital in this city that surgeons who declined to be part of QSS were similarly high-quality surgeons and just as well-qualified lagged about three months behind the QSS surgeons. Every time QSS picked up something good and began to do it, they heard about it in the locker room and were on it 100 days later. You let your leaders lead. The others will follow, but we will never get 100 percent support for some of these ideas.

There was a point that was made about prompter feedback. When you get in the feedback loop, people want that right away. Guys won’t remember cases on Christmas that they did last Easter, and the more prompt you can make any kind of quality feedback loop, the more it means.

The idea of looking for the zero number—which Mike Goldfarb has done a lovely job of the day since the last bad event as a point of pride in a place—is wonderful. How many central lines have you put in without a pneumothorax? And, you know, someday you’ll get a complication and the count goes back to one day and you start all over again. It constantly becomes a reminder of quality in the hospital and/or office.

The motivator issue, about which Frank Lewis made some wonderful comments, is really true. He is also correct about cost and the entire business of the electronic medical record. We’ve got to go there, and stop putting it off.

The point Dr. Flum made about leveraging accreditation programs is really overtly clear. Who ultimately pays for healthcare in America is a simple thing, but it is easy to confuse: the tax payer and the employer. John is nice to be here with us, but he’s strictly just a middleman in this, and all he does is pass the costs on to somebody else. So it’s important to know that the ultimate payer is a public good and a public issue.

Keeping our processes linked to desired outcomes is essential. Dr. Vallance told us that the only place you can get the outcomes that really matters is out of the doctor’s office. I fear that fell on deaf ears. Nobody knows when people go back to work, when they’re allowed to start doing housework, to drive the kids to school, whatever they do, rake the yard, ride the lawn mower. That’s what they want to know this time of year in Kentucky: “When can I get back on my lawn mower?”
That’s only going to come from the doctor’s office. Do not disregard the surgeon as an inexpensive and largely accurate data source.

I obviously agree with a lot of the things Drs. Fry and Vallance said because we’ve worked together so long on all of this. The idea of paying a little bit for doctors who participate or take a lead in NSQIP or any other kind of program will work.  

Dr. Flum: Mr. Grissom, you were actually supposed to be here, I think. We gave your seat away.

Mr. Grissom: Hiram, I got hung up in surgery. (Laughter.) Dr. Luis Scheker said to tell you that.

Dr. Polk: As slow as he is, I can believe that. (Laughter.)

Mr. Grissom: I just want to say Dr. Polk has hit it right on the head. He started out and he gave us the urgency, and he also said, “We’ve got the people here who can do the job.” And it’s absolutely true, and he just went down, the roster of who was here. Those are all the important players in this debate.

I want to go back to the money. It’s interesting Hiram started out with that and he ended with that. It is the federal government that pays for the healthcare and the employers. You know that the Business Roundtable has just tried to get some numbers from the government, from the Medicare program on doctors, who they pay and how much they pay and were turned down. That’s going to be a big fight, but we should not leave here today without realizing that we are, as I said yesterday, we’re at a turning point. The physician fee schedule is in play. It’s going to be changed because it is unsustainable. I would like to see physicians, led by surgeons, go into that debate saying that we want to be paid for performance.

You can go to Gina Pugliese and she can tell you exactly how the demonstration for hospitals works. There’s an important pattern here. It all starts this way. You get paid for reporting, and you don’t get paid positively, you got penalized if you don’t report. Then it goes: “We’ll pay you for performance.” If you report and your outcomes are better, then you get a little add-on. If we lose the opportunity to change the reimbursement system and to put incentives in for starting off reporting and then based on performance, you will have missed a huge opportunity, because this time is not going to come again for another decade.

Every payment system for doctors is in play. The government may just throw money at it this fall to get through the election, but it’ll come right back next year. And the way to get attention and the way to convince the payors that you’re serious and you are not a bunch of hogs at the trough (which is the general perception of the medical profession in this country, certainly in Washington) is to say: Pay us for reporting, pay us for performance, and give them the standards or participate in a consensual process for standards, and people will follow the money.

Dr. Flum: Mr. Grissom, do you envision a point where a surgeon’s participation in a program like NSQIP or a College program could be tied to reimbursement?

Mr. Grissom: Yes. I think you all do have a different problem in that many of you are hospital-based. That’s a problem. CMS pays hospitals more than they pay doctors; that’s why they went there first. There’s more money there and fewer institutions, so it’s easier to control. With you all there’s too many of you, and it’s a lot of money, but it’s not quite as much as for hospitals.

Doctors are number two in line. They’re coming at you. And there is a problem, because you all are based in hospitals, but you still get paid off of the fee schedule.

This problem of who is responsible for quality inside of a hospital, is it the surgeon or is it the staff? That’s a problem, which I believe can be worked out. The point is, all of this stuff is in play. This is the time to strike.

Dr. Pine: May I just add one thing to that, just as a piece of information? The GE Purchaser Group reassembled, the group that put together the Bridges to Excellence program, are starting a new program, which is a new reimbursement system. CMS was at the table, Rand was at the table. They now have a white paper out on the Bridges to Excellence Web site, called the Prometheus Project. They are going to be putting together pilot sites for January of 2007, to assemble professional societies to start working on some of the evidence-based guidelines that will underwrite the system. It would be very useful for you to become acquainted with what they are doing. They are superb marketers and are very well wired. This might be a real opportunity to influence the payors. I think the payors tend to influence the plans. Remember what we learned: If they’ve got you by the pocketbook, your hearts and minds will follow. (Laughter.)

Dr. Flum: So we’re going to move now to a point where we get to hear what you all think and what your priorities are. I want you to know, Dr. Polk, I was listening very carefully as you were talking. I was putting in buckets each of the things you were saying. Many of the things you said are ways that, starting tomorrow, groups, individuals, or even the College could start changing and changing business, including things like linking on to the time-out, which is really how do you effect change immediately and putting in whatever we want in the surgical time-out.

The unique themes that you developed were the ones relating to credentialing. We didn’t really talk about the role of surgeon credentialing inasmuch as we talked briefly about the Board of Surgery issue, and that is a unique theme that we should make is the eleventh so far, the eleventh theme to which we’ll anchor.

The other is the vital issue of the doctor’s office and making sure we anchor to that, and NSQIP-light, are all permutations of what NSQIP should look like.

Eugene Shively, MD: The first one is about unnecessary care and unnecessary testing. I think that’s patient-driven, and I think it’s driven out of fear. If you look at hysterectomies and path reports, this has been going on ever since I can remember, a lot of pathology reports after hysterectomies are benign, and the reason is that patients want it done, and doctors will continue to do it as long as they’re going to get paid for them.

The other issue is, if a patient comes into the ER with obvious appendicitis and the ER doctor has ordered a CAT scan
out of fear, because he’s afraid he’s going to make a mistake and, a lot of surgeons won’t come in and see that patient until the CAT scan has been done for better or worse.

Now, there’s one other issue that I think we need to address and that is the OR milieu. Dr. Jones mentioned that that needs to be studied, and Dr. Greenberg talked about that 60 percent of errors in hospitals are surgically related, and about 40 percent of those come out of the operating room. I have a real good friend named Dick Cook who got a PhD in psychology at IU, and taught over at University of North Carolina when Michael Jordan was playing, and he became friends with Dean Smith and become a sports psychologist. He helped coach and helped do sports psychology with Michael, and he has subsequently become a world-renowned golf psychologist. What he does is that he taught Michael that for every lay up he does, he does it a thousand times in his head. And he also taught him to ignore the crowd and the bogies and the roar in the crowd. He does the same thing on the golf course. If he’s teaching a golfer to putt, he does it in his mind a thousand times. He ignores the crowd. And he teaches him to focus on that. Dick has told me on multiple occasions that you can and should do the same thing in surgery and other endeavors.

We need to get behavioral psychologists and sports psychologists involved in teaching residents, and maybe even mature surgeons, on how we can focus. If you’re in the operating room doing a difficult case, how we ignore the anesthesiologist talking about what he’s going to have for supper, or the scrub nurse, or how we can manipulate them to be quiet so we can concentrate on what we’re doing. And I think that there’s a lot of science in this that we’ve never explored.

**Dr. Flum:** Thank you very much. And I think maybe it will help my short game as well, so I appreciate it. (Laughter.)

**Shukri Khuri, MD:** I think it’s just amazing all of these ideas that came out of our panelists, and I think if we just can achieve one-tenth of what’s been mentioned this afternoon, we’d be doing a lot. I have two points to make. The first is: I still think that we should set some goals for this effort, and we haven’t talked about goals. We all recall, *To Err is Human* said that they would want to reduce errors by 50 percent. I’d like to replace that by saying we’d like to reduce adverse outcomes by 50 percent within a certain number of years as a first goal. As a second goal, I’d like to see us meeting the patients’ expectations by 80 percent, if we can do that. So it’s a two-edged goal. At least that is how I would perceive that.

The second point that I’d like to make is to dispel some misconceptions that I heard in the discussion today about the NSQIP. The NSQIP is not only outcome driven. The NSQIP uses outcome, risk-adjusted, purely as a metric as the very first step of where we need to go. Ultimately the purpose is to develop processes and guidelines that we will try to disseminate so that people can improve outcomes. Unless we have the outcomes, it’s going to be very difficult to identify all of these processes, and particularly, when we talk about outcomes, we shouldn’t be talking only about morbidity and mortality. Obviously we’re just starting and the NSQIP is just in its infancy. Quality of life, functional status, and most importantly, patient satisfaction should be the metric of our goal. All these three are probably more important than morbidity and mortality in the depiction of the quality of the care that we deliver to the patients. What’s important and generalizable about the NSQIP is that it provides for the first time a universal language that hospitals can use together so that we can come together and the basis of it is reliable data. Anything that we need to do or anything that we need to do to achieve must be based on reliable data. The ultimate aim is to develop processes, guidelines, and costs. We feel that you can do it much better if you have a reliable, universal language, and if you have a metric, which is the outcome which you can compare.

**Dr. Flum:** I actually think the panel was right in line with that, that being how to set agenda and priorities, and it’s taken 15 years, in many ways, to incorporate a very small number of process measures in NSQIP, and if we wait another 15 years to have it look 85 percent processed that will have been a mistake. I know Sam agrees with me. I think the comments here were intended to really acutely shift the focus from outcome monitoring, which is essentially what we’re talking about, to these other components. We’re actually on the same page, but it’s just how we want to set the agenda.

**John Clarke, MD:** My first comment is that we have talked about changing the culture and we’ve talked about leadership, and I think we could focus that more toward, first of all, providing education for leaders. Leaders, not only surgeons, chiefs of staff, chief medical officers, CEOs, and board members. We must create some awareness and some passion for this from the top down. Also with regard to leadership, we could really work on endorsing standardization and decreasing variability, and I think we’ve seen some of that, but I think our leaders should come down emphatically in favor of that.

I haven’t heard too much about team training. The emphasis in medicine has always been on individual performance. Dr. Russell will tell you that his daughter is learning that you’re part of a system. There are a lot of people who are in practice now who did not get that in medical school, and we need to go back and, “reskill” physicians in the team concept. That’s not only going to have a direct benefit in terms of improving quality of care, but it’s also going to give people the mind-set that they are, in fact, part of a system. When you’re working with a team, then you realize you’re part of a system.

**John Lewis, MD:** Yes. I’d like to say something about the grassroots approach and how to get it done. I’m a public health physician, and public health physicians have a reputation for being interested in populations and not at all in individuals, and to some extent that’s true! I think for the most part, physicians are very interested in individual patients and not at all interested in populations. So they’re also not used to counting things, and really the way to get quality improvement done, in all of medicine, not just surgery, is to begin to have physicians looking at their own practice and counting their own practice and starting something at that level, as opposed to being imposed by JCAHO or CMS or somebody else. Then the question is: How do you build on that? Well, the individual physician can perhaps compare to the neighbor physician, or compare to
peers, or a group practice would enter some efficiency into this, or a little bigger group beyond that.

I think what we’re getting to is what Quality Surgical Solutions did.9 When I first learned about them about four or five years ago, I thought they were totally unique. They may not be totally unique, but they’re pretty unique. And I was also fairly amazed, being an internist and having mostly worked with primary care physicians, that here was this initiative, a grassroots quality initiative instituted by surgeons for surgeons, looking at themselves, funding it themselves. They each put in money and then they paid themselves for filling out the forms. They were paid for forms, by the way. The IT system Dale talked about improves things, but it starts with a piece of paper. It’s simple enough as Dr. Polk said, $40, not very expensive. That was even when we were paying for it. So I think the effort needs to start at the grassroots.

Now, how do you do it. I do know how. Quality Surgical Solutions did it. Maybe they’re not totally typical in that it wasn’t entirely grassroots, there was already a long history of surgeon leadership in Kentucky, but they also went right back down to the grassroots. I don’t know if Hiram has talked to you about Dr. DeSimone and the rural hospital with one surgeon, but this has focused at that level: One surgeon looking at the ten measures—how am I doing—and then actually publishing that,10 going public with his standards in a very small hospital.

Dr. Flum: I guess the issue is how to sustain that and how to grow that and how to make that a national thing. I think this is really what we’re aiming at.

John Lewis, MD: Exactly.

Dr. Flum: You know, the grassroots approach sounds great. What I’m hearing, though, is, you know, that trying to grow something like this in Washington state, there are a lot of forces aligned against the grassroots movement, not the least of which is paying overhead and sharing data in a competitive business environment.

Dr. John Lewis: Well, I don’t know how to do it other than cloning QSS, but I do think that it has to start at a level in which an individual physician is interested in their own data.

Dr. Flum: I would just call on Hiram, if you were actually going to do anything. That’s probably the short answer and the real answer.

Dr. John Lewis: I think this will be dictated from other people, but if it starts out at that level, it’s going to be much better for everybody.

Kevin Horty: Kevin Horty from General Surgery News. My question concerns how the messages from this meeting will get out to the public. They are being published in the American Surgeon and General Surgery News, so at least surgeons will be made aware. But is there going to be any effort or vehicle to get the messages from this meeting out to the public—to the rest of the country—to show that the leaders of surgery are taking the lead on this and are dealing with these issues head-on?

Dr. Polk: Let’s assume this all comes together over the next three or four months and we end up with a decent document that the American Surgeon and General Surgery News can publish. You’d love to get that in the hands of congressional staffers maybe a hundred-odd influential people nationally and let them hear the sense of what’s behind this, because most of this is going to be transcribed, and that’s a wonderful question of how best to get this word out more broadly.

Dr. Flum: The way qualitative research really works is that themes emerge, they get tested in other groups to see if there are other themes that emerge. Those themes then can get quantified. You can ask questions about how important these themes are. It’s an iterative process. It’s intended in this case to set agendas, to set priorities, and to focus activities. It’s also a good way to define success. Whether or not the public needs to know, how much of that public the needs to know, we’ve actually dealt with some of those issues, but making sure that there’s an exhaustive set of priorities that we have, we’ve explored those priorities in exhaustive ways.

One of the problems is with this language, there’s a lot of overlap between a lot of these themes. If you’re not careful, you have a blob, which ends up just being amorphous and impossible to tackle. We’ve laid out 11 things. I think some of those are quite tackleable, some of them, frankly, in my opinion, are not tackleable, but if that’s where the forces want to align, that would be great.

My recommendation is you take this agenda, these 11 items on this agenda, you test it in other groups, you bring it to the regions, you make the boards—you know, where the board sits with it. You talk about it with JCAHO and CMS, and that’s the way you effect change, one bit at a time.

I just want to make sure about some of these younger outcomes researchers over there in the corner? Caprice, do you have a thought?

Caprice Greenberg, MD: The only thing that I wanted to add was just that I agree with how important it was to look at some of the variations in the utilization. The other aspect of my research relates to disparities in cancer care and some of the differences in the utilizations of cancer procedures. We haven’t talked about that a lot, but if we can start to at least document where the disparities, where the variation is, we can get an idea of how big the problem is and then from there start to try to understand some of the things that underlie those choices.

Dr. Flum: I want to understand. You’re talking about variation in utilization?

Dr. Greenberg: Underuse, overuse, and then the differences. So either, you know, at the institutional level or across different populations of patients based on characteristics, race, socioeconomic, any of those things.

Dr. Flum: We actually have not talked about disparity in this panel. Do you feel like that’s one of the priorities?

Dr. Greenberg: I do. I think that falls under some of the differences in the variation of the utilization. Either break it down based on the institution or you break it down based on the patient population, and then you look at basically how the variations break down based on those different characteristics.

Dr. Flum: And another way to think about that within these broader themes is that the agenda that we’ve set, and
Dr. Lewis said that the priorities of this agenda have to be rethought to be the most important ones. He suggested utilization, Sam has suggested variation, and you’re suggesting some other version of variation, which is disparity.

**Dr. Greenberg:** I think they are all related.

**Selwyn Rogers, MD:** I think I said this yesterday, this issue of the patient that’s a missing element in our conversation thus far. I understand the patient is the ultimate focus of all this conference, but it needs to be said. I’ve been a patient several times. My wife has been a patient just last week, getting a knee arthroscopic surgery. Maybe an unindicated, but she wanted it!

**Dr. Flum:** There you go.

**Dr. Rogers:** What do patients want? I’ll set the stage, because it’s a different conversation. The conversation is around the frame of reference. What is our frame of reference? Are we all homogeneous surgeons who all think alike, or is the frame of reference that we are actually all very different, with different agendas? Maybe we’re setting ourselves up for failure if there’s not first a discussion about what our frame of reference is and then going from there, how can we all align with not just the bodies that are within the room, but all the bodies that we say we serve?

I’m worried that, despite having the eleven and a half or twelve key items, that we may be missing the whole issue of the frame of reference.

**Dr. Flum:** One way to tackle the frame of reference issue by getting distinct themes out and then hash it out. They may not be priorities to all groups. They may not all be coming from the same frame of reference. You know as I listen to Dr. DePalma talking about the very unique set of issues going on at the VA that may not be relevant, may not be the pressure point issues for other practice sites.

If the goal here is to reorient surgical infrastructure, the surgical architecture aimed at addressing quality, with a big Q, one of the ways to deal with the framework issue is to say: Of course we’re not coming at this from the same framework, academic-community, rural-urban, black-white, poor-rich, male-female, cancer-noncancer. It’s all over the place, depending on what you do in your practice, and what you bring to it. At least by explicitly getting these themes developed, then you can start to debate talking about real meaningful points, not just the blurred language of quality improvement or outcomes research. So would that deal with the frame-of-reference issue?

**Dr. Rogers:** It may. I think the other way, I do quality improvement in my own local environment, and one of the things that I deal with all the time is the fact that actually, nurses, physicians, residents, everyone is actually pretty well-intentioned, but we still screw up. So the conflicts of the fact that we’re well-intentioned and well-trained, we want to do the right thing, and it’s not always that we don’t know what the right thing to do is. It’s a choice that we don’t treat the person that we’re taking care of like we would our mother or someone who was like our mother. There’s something about that disconnect between what we do if the person is the ideal person, our kid or our mother or our father, versus what we do if they are “the patient.” I think that’s part of the conversation I think we need to have. I’m not sure if it’s going to fit on the agenda.

**Dr. Flum:** Well, you’re creating systems, though. When you create a system, you can instill those values in your training, in your credentialing, and you’re creating a system. A system has to treat a patient like a patient, so you would hope that the system has people within it that want to treat them like their mother, but the system is intended so that when they have a bad day and they don’t want to treat anybody like their mother, or maybe they don’t even like their mother that day ...

**Dr. Fry:** Or their mother-in-law. (Laughter.)

**Dr. Flum:** Right. That the system picks up the gaps. I mean, is that one of the framework issues you’re talking about?

**Dr. Rogers:** I think it is, and that’s the way to get back to the issue of patient satisfaction. That’s what patients want. They want to actually feel like they’re the most important thing, even if it’s only five minutes that you spend with them. And I’m not quite sure that’s what we do every time we interface with a patient, and that includes the nursing staff, the physical therapist, and everyone who works within the system. We also have a problem, because we still very much function as if we’re the captain of the ships. We walk on the floors, and when I was in Nashville, I would walk on the floor and the nurses would stand up. I was like, “What’s wrong with you? Don’t give up your seat for me. I’m here just—you know, if there’s a chair, I’ll sit in it.” And we still have that hierarchical system, no matter what we say, and we haven’t really advertised the fact that we want a flatter hierarchy and have everyone in the cockpit say, “Hey, you’re about to hit a tree.”

**Dr. Flum:** As I understand the way they did that in the airline industry, is not by saying, “Don’t stand up.” They created a system that demands crew resource management. If you forget to do your time-out, you know, they just don’t move on.

**Dr. Polk:** That’s right.

**Dr. Flum:** They don’t move on. And that’s the difference between saying, “No, sit down,” and creating flattening of the hierarchy by individual choice and having the system do it for you.

In my desperate need to catalog and characterize everything, those comments you made about patient-oriented approaches really nicely fit into the NSQIP issue. If NSQIP is going to be the place that defines the metrics of quality, and one of the metrics of quality must be patient-entered, then I think we have that. We can’t start fixing it until we start measuring it, ie, that old expression that unless you can measure it, you can’t fix it.

**Ralph DePalma, MD:** The idea of the patient-centered-ness is key to this, and what was said about trust is very, very important. What we need to do is win back trust. There’s a chief complaint there. The chief complaint of the public is that there’s an undermining of trust. I think the last point that was made about focusing on the patient and on patient satisfaction and patient outcome, no matter what the outcome might be—sometimes bad—is very important.

**Dr. Flum:** So without belaboring this group that needs to
catch planes, we’ve come up with, give or take, 11 themes that have been vetted by this group and not vetted by others, and those themes may or may not be important. To me, I think that they represent a good set of agenda items. I won’t repeat the 11 themes, because you all will see later this summer.

Have we included all the points that the audience would like to raise?

If we have, I would like to thank this panel and this group for having the opportunity to distill your thoughts and pick your brains. It’s been an honor and a privilege for me.

Dr. Polk, I turn it back to you, and thank you for the opportunity to do this.

I’m deeply indebted to all of you. You’ve given the most valuable thing in the world, your time, and I just appreciate it very much and the surgical patients of the future will appreciate it more. Thank you. (Applause.)

References


