Safety and Quality Improvement in Surgical Practice

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Dr. Pellegrini asked me to talk about what the American College of Surgeons (ACS) is doing with respect to safety and quality improvement. Unfortunately, many surgeons don't think this is a very important area of concern. If you survey surgeons, as we do every year through the ACS Board of Governors, you find that safety and quality are not high on their list of priorities. Topping their concerns are payment, liability reform, regulatory controls, and other problems of this nature.

Surgeon Involvement: A Necessity

So, the bottom line is: where are the surgeons in all of this? I hear that question frequently when I go to Washington and deal with other stakeholders in the healthcare system, such as the Leapfrog Group. They have the perception that surgeons aren't interested in quality and safety improvement efforts. Hence, we must send a very loud and clear signal that we believe it is our professional responsibility to be involved in this movement.

As surgeons, we have a huge obligation to ensure that our patients receive safe, quality care, and I think we are doing better than other physician groups. And we are engaging in a lot of activities that are very innovative and ahead of the curve.

As Hiram Polk, MD, FACS, said previously, surgery today is fairly safe. We are talking about relatively few negative events. So, as we go forward, we have to keep in mind that the system is not totally broken. However, we can't go to Washington and to the policymakers and say, "Look, surgery is fine. There is nothing more we can do. We are just holding the steady line." That approach just won't work.

The ACS has always sought to ensure that surgeons serve patients with skill and fidelity. Nonetheless, some Fellows of our College maintain that we should direct all of our financial and other resources toward tort reform or offsetting cuts in reimbursement. From my perspective, confronting those issues really falls under the aegis of a trade association.

At this time, when the government and the public are most concerned about quality and safety, the College needs to focus on its mission statement, which reflects what we're really all about. Now, I have never been big on mission statements, but I think ours is an important one for a professional organization in this era. It states that we are dedicated to improving the care of the surgical patient and to safeguarding the standards of care in an optimal and ethical practice environment.

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Drivers of Change

The College refined its mission statement about 6 years ago, around the same time as the Institute of Medicine (IOM) released its report, *To Err Is Human*. That and several subsequent IOM papers demonstrate that our current healthcare system needs reforms centered on improving quality and controlling costs.

In *To Err Is Human*, the IOM called for reducing the number of needless deaths in American hospitals by 50%. It's now 6 years later, and nobody really knows whether this report actually has prevented even 1 death. Nonetheless, it clearly emitted a clarion call that we need to revisit health system reforms and to address the causes of medical errors.

Where are we in terms of making at least that much progress? One might say we're sort of at the end of the beginning. We are entering a new era, and we are seeing a shift in emphasis from simply preventing errors to perhaps implementing evidence-based practices to improve overall quality. We are looking at the whole domain of the effectiveness of the services, tests, and therapies we provide to create better outcomes.

Given the new push for standard setting, clearly we are going to work more and more with the development of protocols.

We are going to be looking at outcomes, not just at survival or morbidity, but at whether function has been restored and whether patients who could no longer receive treatment died with dignity. In other words, we're looking outcomes in the large sense.

One of the biggest challenges for us as individual professionals and for surgery as a whole is going to be determining how to best measure quality.

Right now, the government is embracing the concept of linking payment with quality. That is to say, policymakers intend to link payment with service, and the service must meet certain standards. Unless you have the metrics to evaluate quality of care, it is going to be very difficult to maintain a viable practice in the future.

Not only are individual professionals going to be held to a higher level accountability, but hospitals are going to be expected to conform to specific criteria as well. For example, because bariatric surgery is being done more frequently and is performed on high-risk patients who require a certain level of physical and personnel resources, hospitals where these procedures are performed must meet certain standards. Not every hospital in the country can deliver this care safely.

Because they are going to be subject to greater scrutiny, hospitals are likely to develop more rigorous requirements for

granting privileges. Many surgeons would, no doubt, agree that the ability of hospitals to really credential and privilege physicians on the basis of competency currently is very limited. Often hospitals grant privileges to physicians based on when they joined the staff, and little effort is made to ensure that surgeons are still able to competently perform the operations they were initially credentialed to do, say, 20 years ago.

These issues all are centered on concerns about the structure of healthcare delivery. In addition to examining structural issues, we need to look at processes of care. More specifically, we need to develop best practices and the guidelines for surgical care. We also must determine the processes for ensuring that surgeons are implementing best practices.

Outcomes—measuring them and reporting them—are going to key in creating a safer, value-based healthcare system. Surgery is particularly attuned to difficulties involved in analyzing outcomes and realizes that it is impossible to really talk about quality surgical care without some vehicle for reliably assessing outcomes.

The College's Role

So, what is the ACS doing to help surgeons meet these new challenges? Well, let me start by saying that everything we do at the College, whether it be education, research, member services, or our advocacy efforts, revolves around safety and quality improvement.

To begin, our Division of Education is placing a great deal of emphasis on offering programs that will allow surgeons to develop the 6 core competencies identified by the American Board of Medical Specialties: 1) medical knowledge, 2) patient care, 3) interpersonal and communication skills, 4) professionalism, 5) practice-based learning and improvement, and 6) systems-based practice.

For example, we have developed a communication strengthening program, called the Surgeons as Effective Communicators Course: Sharpening Skills for Critical Moments. Communication is critical for modern surgeons. In the past, we weren't evaluated on our ability to interact with other healthcare professionals, patients, or their families. Surgeons didn't have to be communicators. They just said what they wanted, and they generally got it.

Our educational programming also is attentive to the need to develop surgeon leaders. Of course, all surgeons are leaders in the operating room and in their offices. However, many surgeons lack leadership skills. Hence, the College has started presenting the Surgeons as Leaders Course: From Operating Room to Boardroom. Every Fellow of the College, indeed, every surgeon in this country, should take a course like this one so that we can lead safe, highly reliable surgical teams.

To help surgeons build their practice-based learning competencies, we have developed a case log system. This device allows surgeons to track and compare their outcomes.

In addition, we are taking a clear-eyed look at professionalism within the surgeon population. We just finished an analysis of 461 closed liability claims against physicians in San Francisco, Denver, and Atlanta and found a common thread in those lawsuits. In nearly every case, the surgeons transgressed from professionalism. They failed to show up in the ER when a patient was brought in due to a postoperative problem. They didn't obtain informed consent. They did not openly and transparently discuss the risks of the operation and any problems that arose during the procedure.

To help stimulate greater levels of professionalism among ACS Fellows, we have developed a CD-ROM, *Professionalism in Surgery: Challenges and Choices*, featuring vignettes that point to problems in this area. We also plan to more widely distribute another one that many of the program directors now use to train residents. The precept behind this program is that young people can learn to behave professionally, and that, as we traverse our careers, we have to constantly remind ourselves of how to apply these skills.

Another learning tool that we offer with the specific objective of improving patient safety is a guidebook titled S*urgical Patient Safety: Essential Information for Surgeons in Today's Environment*.

In addition, the College has launched the ACS Program for the Accreditation of Education Institutes to ensure that residents and practicing surgeons have ample opportunities to attain and hone their operative skills in safe, state-of-the-art learning environments. Having one meeting a year like this one or the ACS Clinical Congress is no longer a wholly effective means for surgeons to keep up with all the advances in medicine. This model has served us well for nearly a century, but we now need to provide more plentiful and accessible forums for skills acquisition. The institutes that the College accredits through this program will be regionally located (making them accessible) and will be equipped with simulators, so that residents and surgeons can "operate" on inanimate models. I think this approach is very forward-thinking, and I believe we will see the day where we will have 30 or so of these centers throughout the United States.

These institutes will be helpful to surgeons working to comply with new maintenance of certification requirements, which the boards developed to ensure surgical competence. Another College initiative that will assist surgeons in this effort is our Web portal, first proposed by the resident and young surgeon members of the organization. This instrument allows each member of the College to receive online information customized to match his or her special interests. eFACS.org also will allow surgeons to transmit their case logs, continuing medical education credits, and other required documentation to the boards and to regulatory agencies.

Another educational tool that the College provides is *The Surgical Index*, which lists the best of the surgical literature available online every month.

Furthermore, we are developing a PGY-1 curriculum that cuts across all the specialties. To develop this multidisciplinary program, we are receiving input for the surgical specialties, including neurosurgery, orthopaedics, otolaryngology, and so on.

Turning to the College's efforts to measure and evaluate quality care, our Division of Research and Optimal Care is making great progress in this arena. For example, we believe facility certification programs are going to be very important in the future. For many years now, the College's Commission on Cancer and Committee on Trauma have accredited facilities that provide oncology and emergency

care. Following up on these successful efforts, we recently launched the ACS Bariatric Surgery Center Network Program to accredit and evaluate facilities where weight-reduction operations are performed. The American Society of Bariatric Surgery has introduced a similar program, so we now have 2 national programs looking at facilities where these operations are performed.

I can foresee a need for the College and other organizations to accredit other types of facilities as well. For instance, the Joint Commission on Accreditation of Health Care Organizations estimates that there are approximately 40,000 freestanding office-based facilities in the United States, most of which have no certification, no oversight. This is a void that must be filled.

Likewise, we need to address disparities in treatment. For example, spine surgery is performed by several different specialties, each of which uses different techniques. We need to establish standards for the performance of such serious types of operations. Furthermore, we need to bring stability to gynecologic surgery, vascular registries, and many other areas as well.

To help generate quality measures that applicable in the surgical setting, we have been moving the National Surgical Quality Improvement Program (NSQIP) into the private sector. This program originated in the Department of Veterans Affairs' health system, and it is the only validated, risk-adjusted measure of surgical outcomes. More than 80 U.S. hospitals are now involved in ACS NSQIP, and we are enrolling about 6 to 8 new hospitals every month. We anticipate that ACS NSQIP is going to be a very important instrument for analyzing outcomes among hospitals and perhaps, eventually, individual surgeons.

Other quality improvement-related initiatives that the College is leading include our clinical trials programs, beginning with the establishment of the American College of Surgeons Oncology Group (ACOSOG) in 1998. ACOSOG has had limited success because we have had trouble recruiting patient and surgeon participants. Nonetheless, the College needs to have a good clinical trials program, not only in cancer but perhaps in other areas as well, such as trauma, burns, critical care, and so on.

In addition, the College is making better use of our National Cancer Data Base and National Trauma Data Bank to generate comparative information. These databases have sort of languished in the past, but we are doing everything we can to bring them up to date. We are bringing in new surgical investigators into the College to really start using these databases to their full capacity.

It is important to acknowledge that no organization can carry out all these quality improvement activities working in isolation. Hence, the College is working with the Centers for Medicare & Medicaid Services in its effort to introduce the Surgical Care Improvement Program, which is a process-measurement vehicle for hospitals.

We also are building a collaborative relationship with the American Medical Association, which directs a Physicians Consortium for Quality Improvement. We play an active role in this group because it is the first stop en route to receiving approval for quality measures.

If the metrics get through that filter, then they advance to the next review group, the National Quality Forum (NQF), which recently approved several quality indicators presented by our Commission on Cancer. And if they attain NQF's approval, they go to the newly formed group called the Ambulatory Care Quality Alliance. The College is committed to building and maintaining strong relationships with all of these groups to help ensure that appropriate quality measures are applied in evaluating surgical care.

I'd like to conclude by saying something about membership. The ACS never uses the "R" word, "recruitment." Membership in the College has always been considered an honor, and it still is. However, for all the reasons mentioned during this panel discussion, we need to encourage every surgeon of every specialty to become part of this organization and to participate in our programs. Surgery and the practice of medicine are becoming more and more regulated, and surgeons are going to need to be members of groups that can help them to keep track of what they are doing and transmit this information to the appropriate boards and agencies. They will have to continually pursue the requisite education programs for surviving a more competitive practice environment, for remaining competent, for maintaining certification, and for staying on top of technological advances.

One of the major developments that has occurred at the College to encourage lifelong membership in the organization has been the establishment of the Resident and Associate Society of the College (RAS-ASC). The RAS-ACS has proven to be a valuable addition to our organization. To give you an idea of how much the RAS is spearheading change within the College, the Regents recently agreed that a resident may serve on any single committee of the College, and may chair any single ACS committee other than the Central Judiciary Committee, which deals with sensitive disciplinary matters. I believe the residents and young surgeons are really driving some very healthy readjustments in our attitude and direction.

In addition, the College has established an affiliate membership category, so that all members of the surgical team can participate in shared learning experiences. Affiliate membership is available to nurses, anesthesiologists, nurse anesthetists, surgical technologists, physician assistants, office managers, the range of healthcare professionals involved in delivering surgical care.

I also want to say that we are making a real to communicate with our members. We have developed numerous communication vehicles, including the *Bulletin*, *ACS NewsScope*, and periodic e-mail alerts.

As a final thought, I want to emphasize that all surgeons need to break out of the silos that many of us are in. I'm in a silo. I am in the surgical silo. But to improve overall patient safety and quality, we have to start thinking more globally about healthcare reform across all the specialties, across the whole profession, not just the surgical component.

I realize that I am way over my time. Please excuse me, but I have really appreciated this opportunity to share with you some of some of the tangible and concrete efforts that the College is carrying out to improve patient safety and quality. We think we are making some progress.