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Quill on Scalpel
Plume et scalpel

To be or not to be a part of the solution

Jonathan L. Meakins, MD, DSc*

The opinion piece by Gross in this issue (page 421) has been reviewed by the Editors and is being published because it represents a widely held view among surgeons and other resource-intense physicians that they are somehow shortchanged by "The System." We did not send it out for peer review because the flavour of the "angry (young) surgeon," as Gross has acknowledged, would have been lost. If we had, what modifications would we have requested before publication? Specifically, we would have asked that the author:

- provide data on the inadequacy of the present inventory of implants;
- provide evidence that his hospital's purchasing system is unique and biased;
- provide outcome analyses sufficiently independent of implant manufacturers that argue for a broad inventory;
- modify the capricious and self-serving tone of the paper and provide data to support the arguments; and
- justify the validity of "ethical" in the title.

We sent the manuscript to a number of health economists, hospital presidents, surgical leaders in hospitals and universities, deans, foundation presidents and orthopedic surgeons. Not all have replied. For many, the criticisms of the manuscript made it too difficult to articulate a reply because too many issues were raised. Indeed one reply stated: "This sort of article demands a significant amount of data, with detailed economic analysis, legal analysis, and cogent ethical argument."

In general, we agree with these observations. But in the absence of the perfect article, we have opted to publish Dr. Gross's opinion and use it as a focus to identify what surgeons might, indeed must, incorporate into their institutional behaviour in order to defend their patients' best interests, cognizant also of society's best interests. We surgeons must be careful that what we defend are not our capricious needs but those of our patients. Although every doctor–patient relationship may have 2 patients, we must recognize which patient we are looking after. We have signalled Dr. Gross of our intention and of the nature of the external criticisms. He has made some changes and has indicated that he "looks forward to the debate."

The responses we have received are quite variable in length and structure. Short or quotable replies have largely been integrated into this Quill on

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Scalpel, with or without direct attribution. More complete responses follow Dr. Gross's article. Many responses were directed to specific aspects of the article, but as my earlier quote indicates there are many sides to this subject.

Observations by several can be summarized as follows. Gross presents us with a mélange of issues including physician reimbursement, compensation and supply costs. The sources of these are different budgets which will not be co-mingled. Although, as Dr. Gross points out, "the surgeon continues to bear the responsibility for the outcomes of surgical procedures," we surgeons have done a poor job in determining these outcomes and have not relied on objective measurements to determine the usefulness of procedures or different implants. Whereas there is scepticism about some aspects of evidence-based medicine, its absence is more troubling and demands that we view opinions with the same degree of scepticism.

Timothy Brodhead, president of the J.W. McConnell Family Foundation, has addressed the ethical component:

The dilemma Dr. Gross poses is not so much an ethical one as one of cost and accountability. "A well-trained surgeon who is ethically aware and acting in the best interests of the patient will use the equipment appropriately, in the expectation of obtaining a good result for the patient. . . . This all costs money." Precisely. In a market-driven health care system, there would be no dilemma: the patient gets what he or she is prepared to pay for (the ethical issue then is, is it acceptable that the care people receive is determined by what they can individually afford?).

In a socialized system of health care, who is ultimately responsible for deciding what is in the best interest of (all) patients: the doctor, the bureaucrat, or the Minister of Finance? Who is best informed about the real costs (not "hidden" in the price of implants) and the inevitable trade-offs between quality of care and price? At what level should those trade-offs be made: the individual patient, the institution, or the system as a whole in relation to other societal needs? It may be unethical for a doctor not to provide a patient with the best possible care, but it may equally be unethical, say, to deprive young children of quality daycare in order that a ninety year old gain an extra six months of life.

What we lack, as a society, is the more sophisticated accounting and management tools to cope with our new austerity and to enable us to make choices in an informed and responsible way. Cost has always had a determinant role in allocating health care resources, except for a brief period, now ended, when it seemed that Canadians faced no constraints. Surgeons cannot be held uniquely accountable when they do not have, cannot have, full control over the means to exercise that responsibility. We elect politicians to allocate society's resources; how much goes to maintaining our health (or, perhaps more pertinently, how it is allocated *within* the health system) rather than to building, say a bridge to PEI, is ultimately something we should decide at the poll. Surgeons, like most of the rest of us, work with limited means and cannot be blamed if they can't produce miracles. Passing the buck ain't ethical either.

A renowned health economist, Judith Maxwell, OC, president of Canadian Policy Research Networks Inc./ Les réseaux canadiens de recherche en politiques publiques inc., points out:

Dr. Gross is concerned that there are two competing perspectives with respect to the choice of surgical implants. He notes that surgeons select implants based on their assessment of the best interests of the patient, while hospital administrators are interested in controlling costs through bulk buying, thus reducing the selection of implants available to surgeons.

In health economics, these two perspectives are complements. Relating costs to the quality of health outcomes is the essence of economic evaluation, and should be the foundation for informed choice by administrators and surgeons. The guidelines for conducting economic evaluations specify how costs and outcomes should be measured.[1,2]

Once the efficacy of the implant has been determined then we can look at cost-effectiveness. The object here is not to buy the cheapest implant, but to know which implants would achieve the same outcomes or possibly better.

Focusing on cost-effectiveness is essential to the sustainability of the health care system. In times past, costs were not always a constraint, and outcomes were implicit in the choices made by the provider. Now that resources are constrained, we have to invest in appropriate measurement of unit cost and in establishing objective outcome measures. With that information in hand, evidence-based decisions are possible — decisions that satisfy the objectives of minimizing cost and maximizing the well-being of the patients. In many cases, the potential savings to the system are remarkable.

Indeed, in Sustainable Health Care for Canada, Douglas Angus and his colleagues uncovered many situations where the substitution of an alternative treatment or care setting generated savings of as much as 85 cents on the dollar, always while achieving similar or better outcomes. The challenge is to give decision-makers the evidence they need to make wise choices — wise for the patient and wise for the system as a whole.

E. Scott Rowand, president and chief executive officer of the Hamilton Health Services Corporation, looks at Gross's comments from the financial and managerial side. Indeed, his final paragraph makes the clarion call that administrators and clinicians must collaborate if real progress is to be made.

Gross offers a widely shared view that surgeons are unduly singled out in hospital cost-cutting exercises. It is true that hospitals too often focus their budget balancing exercises on big ticket items such as joint implants. A diversity of surgical styles is often desirable — although rate variation and volume related outcome studies would suggest that too much variation is not appropriate.

As in most things, however, all is not black or white. Clinically inept hospitals are unlikely to survive, but those which are financially incompetent are sure to fail. Virtually all health care decision-makers — clinicians, administrators, manufacturers, and government officials — are

subject to conflicts of interest. The different, but necessary skills of the manager and the physician are both needed to operate our complex health care enterprises. There are fundamental but difficult questions around the allocation of resources based on need versus benefit.

Gross's characterization of encouragement by hospital management of surgical staff to standardize supplies and equipment as being unethical is going too far. Malevolence is not at work as both surgeons and administrators usually act with the best of intentions. Determining the greatest good for the greatest number, however, is often a matter of perspective. Rather, I think the problem is one of incomplete information regarding the cost utility of various procedures and the absence of explicit and commonly agreed health care system goals and objectives to guide health care expenditure decision-making. . . .

In tackling complex and difficult questions which have no right answers, a collaborative rather than an adversarial approach is necessary. Canada's health care system, and indeed those throughout the world, will continue to struggle to find ways to do more with less. Clinicians and administrators together must develop better processes which lead to the best possible decisions in the face of imperfect knowledge. Finding better ways to properly allocate health care resources is worth the effort because the stakes are enormous, and the damage that can result from poor choices, devastating.

Gross points out the frustration that many surgeons feel in the present climate of fiscal restraint in health care, which, it is worth noting, is taking place everywhere in the western world. Those frustrated say they work only for their patients, they are efficient, cost conscious and can do no more. What would they say to the following true scenario. L'Institut de Cardiologie de Montréal and the Royal Victoria Hospital compared costs per patient for their aortocoronary bypass programs. The costs were equivalent. However, if details of stay in the intensive care unit, drug use and other resources utilized were examined, there were significant differences. (Costs per patient — outcomes in the 2 units were equivalent — would have been significantly reduced with use of the best, and often least costly, practices.) The implication, of course, is that many of our complex procedures can likely be done for less, just as it has been shown that herniorrhaphy, arthroscopy, laparoscopic cholecystectomy and many other procedures can be day cases, allowing beds to be closed without a reduction in patient service or volume and with comparable outcomes. What Canada does not need is the insertion of the managed care approach to cost cutting. We are still a liberal profession with the ability to deliver high-quality surgical care with a minimum of interference from administrators. We are not harassed daily about bed use, admission criteria, resource use, length of stay and so on. To preserve this situation, we surgeons must be prepared to be a part of the process and to be at the table, not with opinions but with data for decisions. Economic evaluation is complex. Where there are obvious questions, let us pose them and find the answers. As has often been said: if you are not part of the solution, you are part of the problem.

Significant input from the following is acknowledged: Paul Walker, MD, Vice President, Surgical Directorate, The Toronto Hospital, Toronto; Cecil H. Rorabeck, MD, Chairman, Division of Orthopedic Surgery, University of Western Ontario, London, Ont.; Judith Maxwell, OC, President, Canadian Policy Research Networks Inc./Les réseaux canadiens de recherche en politiques publiques inc., Ottawa; E. Scott Rowand, President and CEO, Hamilton Health Services Corporation, Hamilton, Ont.; Timothy Brodhead, President, The J.W. McConnell Family Foundation, Montreal; Nelson Mitchell, MD, Associate Dean, McGill University, Montreal, Que.; Céline Doray, RN, MSc, Nursing Director, Surgery, Royal Victoria Hospital, Montreal

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[Additional comments from Drs. Eric Latimer and Renaldo Battista, Charles Wright, Conrad Pelletier and Robert McMurtry follow Dr. Gross's article (see pages 424 to 429).]