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CURRENT COMMENTS

Shopping for a Surgeon

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The awakening of the consumer movement in recent years has aroused interest in the quality of a variety of goods and services. Along with automobile safety, food additives, bio-degradable detergents, and the dangers of environmental carcinogens, the American public is beginning to devote its attention to the quality of medical care, especially in hospitals. The recent sharp rise in medical malpractice suits has sharply focused the interest of doctors on the same area of concern.

Unfortunately, the medical profession itself does not maintain a statistical record of the vast number of operations undergone in this country. Individual hospitals keep registries of their surgical activities, but no one gathers and disseminates this information on a national basis. Clear information with which to evaluate the performance of doctors and hospitals is scarce. However, a few researchers have studied and reported on the surgical practices of American doctors.

For example, last year a Harvard University report on surgical practices found that "far too many physicians perform surgical operations and that work loads of surgical specialists are modest."[1] In this report, Dr. Rita J. Nickerson and her colleagues suggested that the total number of operations reviewed for this study "could have been handled by a substantially smaller cadre of busier surgical specialists." They also found that some doctors who operate, including some surgical specialists, fail to perform enough operations to maintain a high level of skill. General practitioners with no special training in surgery were sometimes found to be performing such operations as appendectomies and hysterectomies.

Dr. Francis Moore, a surgeon at Harvard Medical School, called the Nickerson study "a landmark in the study of delivery of surgical care in the United States."[2] He commented that "there are too many people carrying out surgical opera-

tions in America, even though the highly trained and Board-certified surgeons could evidently carry the load easily and safely. This finding means that the current system for 'credentialing'--that is, identifying in each hospital the persons who should have the privilege and responsibility of major surgery--is much looser in the US than in comparable westernized countries. General practitioners do many operations, largely tonsillectomy, uterine dilation and curettage, and obstetric delivery." Moore also notes that "where there is a larger proportion of surgeons in the population...more operations are performed but fewer by each surgeon, and the specter of 'supplier-induced demand' is raised."

But the view that some physicians exploit their patients would seem to be contradicted in a 1974 article by Dr. John Bunker and Dr. Byron Brown, Jr. of the Stanford University School of Medicine.[3] They examined the utilization of surgical services by several West Coast professional groups including physicians, lawyers, ministers, and businessmen. Surprisingly, they found that physicians and their spouses had quite high surgical rates. "Physicians' wives tended to have more operations than wives of the other three professional groups; they underwent appendectomy and thyroidectomy significantly more often than lawyers' wives, cholecystectomy significantly more often than lawyers' and businessmen's wives, and hysterectomy significantly more often than businessmen's wives." What these results indicate, contend the authors, is that "the alleged overuse of surgical services" is not due to "a lack of consumer knowledge." On the contrary, since they assume that physicians and their spouses would be aware of the best medical procedures, the authors suggest that "as the public becomes more fully informed, the demand for surgical services will increase."

An article which appeared in *Medical World News* entitled "How Much Unnecessary Surgery?"[4] also raises some interesting points. According to the article, Harvard professor of community health Charles E. Lewis analyzed Blue Cross surgical records for 1965, finding extreme variations of surgical rates according to demographic region. Dr. Lewis sought an explanation for these variations and discovered that "those regions with the highest incidence of operations also had the higher proportion of physicians (both GP's and surgeons) who did surgery and the highest proportion of hospital beds. Dr. Lewis speculated that he might have stumbled onto a medical variation of Parkinson's Law: 'Patient admissions for surgery expand to fill beds, operating

suites, and surgeons' time'."

This "law" is disputed by a Philadelphia surgeon, Dr. James Mullen, of the Hospital of the University of Pennsylvania. Mullen questions whether a high regional rate of surgery necessarily indicates lower quality of care. "A high surgical rate may mean good surgical care,"[5] he claims. Mullen points out that in England patients must often wait long periods of time to have elective surgery performed. This waiting list results in a lower surgical rate, he says, and represents a lower quality of care for the patient who is forced to wait for a needed operation.

Along with Mullen, Dr. Robert Tyson, Director of Surgery at Temple University Hospital in Philadelphia, examines the criteria which determine "quality" in surgical care.[6] It is inaccurate, he asserts, to label most surgery performed by general surgeons as either unnecessary or incompetent. General surgeons *are* surgical specialists, he says. Besides assuming the primary responsibility for teaching surgery in medical schools, general surgeons actually form the foundation of surgery. They may be even more important than the specialist. "More people need general surgeons than, say, plastic surgeons, or neurologists or urologists." Mullen adds that a general surgeon may require 5 years of training after internship, whereas some specialists, such as urologists, may require only 3 years.

Compared to specialists, general surgeons may be able to give more personal attention to the patient before and after surgery. Dr. Franz Ingelfinger, editor of *The New England Journal of Medicine*, comments that, "The care in a community hospital from everyone may be much more personal and hence much more life-sustaining than in a huge factory center of surgery. Everything counts in the outcome, not just how adroitly the surgeon wields a knife and the needle. I personally know some excellent community general surgeons who are perfectly competent to perform the type of operation most commonly carried out, even though I would not ask them to do major gastric resections, total colectomies or any major cancer operations."[7]

I myself am wary of operations performed in scientific institutes where various surgical techniques are tested under "trial" conditions. But Dr. Ingelfinger assures me that "the more scientific the institution the more likely surgeons are apt to use one or two highly specific techniques to make appropriate comparisons, the controlled trial gradually becoming practiced by surgeons as well as internists. The more 'scientific' the institution, the less chaotic ad hoc trials of all sorts

of procedures."

So it seems that it is difficult, if not impossible, to objectively determine a surgeon's ability. Doctors themselves disagree on the criteria necessary to make a choice. Dr. Mullen says that he usually receives two or three phone calls each day from people asking his opinion about various local surgeons. Their final choice of a surgeon is based largely on informal, subjective peer evaluation.

One source of statistics which people might find helpful in selecting a surgeon is not available to most of them. It is the quarterly publication *Hospital Record Study*, which contains diagnostic and surgical data on about 2,200 hospitals in the US and Canada. Since a single subscription is priced at several thousand dollars, its distribution is limited. In fact, the total subscription list, which numbers less than 25, is composed primarily of drug companies and medical and surgical manufacturers who study hospital trends with a keen eye toward new, marketable products. The *Hospital Record Study* is published jointly by the Commission on Professional and Hospital Activities of Ann Arbor, Michigan, and International Market Systems of America of Ambler, Pennsylvania.

We called these organizations to obtain a sample of their data. The Commission on Professional and Hospital Activities informed us that the information is available only to subscribers. As a matter of policy, information can be released only with the consent of the individual hospital involved. At International Market Systems of America we received a similar explanation.

However, ISI® was able to obtain a report published by the National Center for Health Statistics, entitled "Surgical Operations in Short-Stay Hospitals."[8] It is based on data collected by the Hospital Discharge Survey and gives estimates of the surgical operations and procedures performed during 1971 in non-Federal short-stay hospitals. Unfortunately, the data are not very current, and not specific enough to guide a consumer to a particular hospital where the surgeons have superior records for success.

In light of some of the above findings, it seems clear that those who "shop" for a surgeon are well advised. "Shopping" does not necessarily mean searching for the cheapest surgeon. As in other types of shopping, the prudent consumer considers both quality and cost.

One wonders if the newly proposed peer review system will give prospective patients a chance to examine physicians' track records. In an editorial last year the president of the *Illinois Medical Journal*, Joseph H. Skom, discussed the potential merits of the peer review

system.[9] He comments that it would be effective not only in weeding out "the few charlatans and quacks in our profession," but would also enhance continuing medical education programs. Dr. Mullen, however, thinks that even if the results of the peer review system were made public, its effectiveness would not be assured. The hospitals which earnestly attempted to present accurate records, he contends, would be compared to other hospitals which might not be so eager to present self-deprecating facts.

Unfortunately, reliable information on the quality of medical care in the U.S. is sadly lacking. The available information is often contradictory. The only comprehensive data compiled on a national basis are intended solely for the use of the pharmaceutical industry. By limiting its distribution, the firms which compile and publish this data may be missing an opportunity. However, if the information is not made available to the public by these private firms, then the National Center for Health Statistics should be encouraged to do so.

Until reliable, comprehensive information on the performance of doctors and hospitals comes along, one should always seek second and third professional opinions concerning the necessity of major surgery. The life you save may be your own.

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