

A Question I Should Be Able to Answer

A Young Physician's Perspective

Jason Sarfo-Annin, MD – Acute Medicine Doctor
at Royal United Hospital Bath NHS Trust, UK

It was my first week as a cardiac surgery senior house officer (resident), and I was excited about the job. Wanting to make a good impression, I reviewed the procedural aspects, risks, and complications of coronary artery bypass surgery in great detail. I expected that I was either going to be tested on this knowledge by the consultant (attending) or be asked by one of my patients.

A nurse approached and informed me that a patient wished to speak to me about his upcoming coronary artery bypass surgery. This patient had just been transferred to the cardiac surgery ward. I reviewed his notes, attended to the patient, and asked how I could help.

"Doctor, I want to know more about this operation," he said.

So, with my newly acquired knowledge, I explained to him the nature of his coronary artery disease and the risks of doing nothing. I then went into the details of the operation and intra-operative, early, and late complications. After a few more questions about the operation itself and his

needing to be in a high-dependency unit after the operation, the patient seemed satisfied. However, my feeling of accomplishment vanished after I asked if he had any more questions.

"One last thing. How long will it be before I can go home after surgery, and how quickly will I be able to get back to my regular life? I need to be able to take the dogs for a walk in the mornings and would like to play football with my grandson. My wife also isn't too well, so I would like to get back home as soon as possible."

I stood there, flummoxed. It was a completely reasonable question and one I felt I should be able to answer. I just didn't know if he would be able to perform these activities as well as he was hoping to.

During my time working in cardiac surgery, patients have asked about outcomes ranging from the cosmetic appearance of a surgical scar, to how frequently they would need to use anti-anginal spray. I soon learned that output from services – a patient with blocked coronary arteries having surgical revascularization – and



a desired outcome for patients – spending a day at the shopping mall without anti-anginal spray – were not always quite the same thing. Indeed, we are taught to ask patients about their ideas, concerns and expectations, but it doesn't seem that we have made this central to how we practice medicine. I think we need to. And because patients often have their first and most frequent contact with us junior doctors, we are well placed to help make outcomes-based health care a reality.

I have learned that bridging the outcomes gap that I experienced with this patient and others requires me first and foremost to appreciate that such a gap exists. Secondly, to specifically ask for ideal outcomes before planning further management, and third, to facilitate these outcomes in conjunction with the hospital-based multi-disciplinary team. The care from the cardiac surgeons, the anesthesiologists, the physiotherapists, the specialist care nurses, the psychologists and so on combine to provide the outcomes for my patients. Not all of these care providers would have been privy to the outcome-related information provided to me by the patient unless I (or the patient) had explicitly informed them.

This holistic approach is what I as a teenager envisaged medicine to be. Being a good clinician is important but not the only factor that

makes a good doctor; something more is needed. As a medical student I thought that being a good communicator was that "special something," but my first few jobs since medical school have highlighted that it is something more. You can be as fantastic an orator as Barack Obama or have the clinical acumen of Gregory House, but if you don't ask and engage with both a patient's story and his hopes and desires for when he no longer needs you, then you will never have an engaged patient. It sounds so simple, but I have come to the conclusion that understanding how a patient feels and therefore understanding what he wants is that "special something."

A doctor with that "special something" is what I still hope to become. This is why ICHOM's outcome-based approach is so exciting: it delivers the satisfaction that you have provided something that a patient wants. Isn't job satisfaction part of the attraction of being a doctor? Whatever a junior doctor's specific motives for studying medicine, we all in some way want to help people. Medical students proceed through medical school assuming that this means treating medical conditions. Outcomes-based medicine would provide a vehicle for uniting our desire to do good with the goals that truly matter to patients.

"I Wanted Us to Use Outcomes to Constantly Question the Status Quo"

An Experienced Physician's Perspective

Hartwig Huland, MD – Head of Department at Martini-Klinik, UKE Hamburg, Germany

I have devoted much of my medical career to improving treatments for localized prostate cancer. When I was appointed Chair of Urology at Martini Klinik, Hamburg University Hospital in 1992, prostate cancer, though extremely common, was still an inconsistently treated disease. In those days, I found myself completely in the dark about my patients' results, since post-operative care was left to the private urologists outside the hospital who had referred patients to us in the first place. I tried hard to build my own database to store follow-up information, which was mainly used for clinical research at first. There was no real IT system, limited enthusiasm from my residents and from the referring urologists, and no support from clinic management or from our German grant system to finance more staff members.

A few years later, a patient of mine made an extremely generous endowment to the urology department. There were many things I could have done with the donation: build a new hospital wing or laboratory, run a clinical trial or develop more marketing tools. Instead, I decided to invest in an outcomes database. Looking back now, this was one of the best investments I have ever made.

We started by collecting outcomes data in a spreadsheet for every patient we treated. We'd enter all the data ourselves at the end of each day after clinic. As our database grew, we decided to form an "outcomes study group," made up of two documentation assistants, two database technicians, and two research fellows, dedicated to managing the data-capture process alongside clinical staff. Despite the volume of data we collect, ours is an uncomplicated, unfussy system to manage.

Jason Sarfo-Annin, a young physician in the UK, recalls an early moment in his career when a patient's simple questions about resuming daily activities post-operation left him utterly stumped, despite years of medical training. As Sarfo-Annin notes, patients want to survive an illness or an operation, but they want more than just to survive: they want to walk their dogs, play sports, and return to their active, normal lives. To provide the best care, this needs to be ingrained into the way physicians practice.



We had data, and now we needed to decide how best to use it. I wanted to use the outcomes to challenge the status quo, to adjust old methods or uncover better ones. In 1974, as a resident at Stanford under Dr. Thomas Stamey, I remember being impressed with the open learning culture Dr. Stamey had created within the urology department: he and his colleagues would publish reviews that analyzed and discussed outcomes data. It was a brilliant way to identify weaknesses and build on successes, and I concentrated on developing a similar culture at Hamburg.

Our department didn't just measure patient outcomes; we openly discussed the results with other physicians performing the same operations. The goal was to understand why we found the results we did. Why did one technique, for instance, produce better outcomes than the other? Every six months, we produce individual outcomes reports for each of our surgeons, which include everything

from average blood loss to incontinence. We hold regular meetings to review the data and to reflect on our methods. Surgeons with better outcomes help train those with less favorable outcomes.

Our clinic finds the challenge of evaluating outcomes data – such as the benefit and harm of additional radiation after surgery – incredibly stimulating. We love being able to participate productively in international research groups like the International Cancer Genome Consortium and the International Consortium for Health Outcomes Measurement. Our investments in outcomes measurement have already paid off: we have seen higher revenues and an influx of new patients from within Germany as well as from other countries.

Most importantly, our patients are happier: for many years now, we have found that 98 percent of our patients would recommend us to a family member or friend. We are currently also the largest prostate cancer center in the world. We have complication rates far lower than the national German average. And we are still striving towards the best possible outcomes for our patients.

Professor Hartwig Huland, who has been Head of Department at Martini-Klinik since 2004, shares how the Martini-Klinik, a special clinic for prostate cancer treatment, boosted the quality of care offered to its patients by systematically measuring results after surgery and learning from that data.

Prof. Huland is the president of the German Association of Urology and a member of the German, European and American Association of Urology.