



PIPS *Steps*

A PUBLICATION OF THE PITTSBURGH INSTITUTE OF PLASTIC SURGERY

BATTING AVERAGES

While I'm not a hard-core baseball fan, nonetheless I do enjoy following the exploits of not only our hometown Pittsburgh Pirates but also other baseball teams with which I am connected, at least indirectly by virtue of time I spent during my education and training in cities in which those baseball teams are located. I never cease to be amazed by a baseball announcer's ability to rattle off volumes of information, such as pitching and batting statistics, about any baseball player. For instance, the performance of a certain right-handed batter against a certain left-handed pitcher with a certain number of men on base in a certain ball park.

There is no doubt in my mind that the average patient (certainly just about all of my patients) would like similar information about their physicians, particularly surgeons who by definition become more "intimately" involved with their patients than do non-surgeons. I'm sure many of my patients would like to know what my batting average is. How do I perform with regard to a certain surgical procedure undertaken on a patient of a certain age, height, weight, etc. on a certain day of the week at a certain time of the day? I think you get the picture. While of late hospitals and health insurers, in response to pressure from consumer groups and government agencies, have undertaken statistical analyses of the performances of surgeons, particularly cardiac and other surgeons who deal with life and death situations on a routine basis, these statistical analyses, without appropriate supportive information, usually are flawed from the outset and consequently meaningless at best and potentially dangerous at worst. Let me explain.

Some years ago while I was in training in general surgery at Georgetown University Hospital (GUH) in Washington D.C., I worked with a remarkable surgeon who dedicated himself to the treatment of particularly difficult surgical problems other surgeons refused to touch. At GUH he became the "court of last resort". Not surprisingly his mortality rate (in other words the number of patients who died while under his care) probably varied at anytime from 10% to 15%, which even a non-physician would agree is a remarkably high percentage of deaths. Judged by his mortality rate alone, most people, even knowledgeable physicians, would assume him to be a terrible surgeon and one who should be prevented from practicing medicine. Yet those of us who worked with him and knew him well recognized that, given the nature of the patients and surgical problems who/which he treated, his mortality rate of 10% to 15% was unusually low. In the hands of a "lesser" surgeon, that same mortality rate might be 50%. Consequently, he was curing anywhere from 3 of 10 to 4 of 10 more patients than would/could other

surgeons faced with the same "mix" of patients and surgical problems. Needless to say, to those of us in the know, he became the surgeon of choice, even for minor surgical problems.

In like manner the success rate, complication rate, medical malpractice suit rate and so on of any surgeon often are a function of factors not related to his/her competence or abilities. Complications such as post-operative bleeding, infection, tissue death and loss, etc. can arise even under the best of circumstances and despite the best efforts of all "parties" to a surgical procedure. My complication (and "re-do surgery") rate for Rhinoplasty (nose reshaping) is virtually 0%, compared to a nationwide rate of 1% to 2%. My complication (and "re-do surgery") rate for Bilateral Breast Augmentation is in the neighborhood of 1%, compared to a nationwide rate of 4% to 5% and even more. In other words, essentially none of my Rhinoplasty patients require additional unanticipated post-Rhinoplasty surgical care whereas about 1 in 100 of my Bilateral Breast Augmentation patients do require additional unanticipated post-Bilateral Breast Augmentation surgical care. At which of the foregoing two surgical procedures am I more competent? Rhinoplasty, because of my 0% complication/"re-do surgery" rate? Or Bilateral Breast Augmentation, because my complication/"re-do surgery" rate for that surgical procedure "beats" the corresponding national rate by a wider margin than does my complication/"re-do surgery" rate for Rhinoplasty? Many of my patients would like to think that the competence or lack of competence of a surgeon can be determined by the number of medical malpractice suits filed against him/her. In fact, medical malpractice suits these days are more a reflection of the litigious society in which we live, the vulnerability of physicians to such suits and certainly, in my specialty at least, the difference between the expectations, sometimes unrealistic, of a patient undergoing surgery and the ability of the surgeon/surgery to meet those expectations.

My point, I'm sure you've guessed, is simply that statistics, particularly with regard to performance by physicians in general and surgeons in particular, are meaningless when those statistics are evaluated in a vacuum. They are meaningful only when many variables, some of them confusing even to other physicians, are factored into the analysis which produces those statistics. Perhaps one day as surgeons enter operating rooms across the country to ply their crafts, disembodied voices will introduce them over loudspeakers in those operating rooms and provide those assembled in those operating rooms with information about each surgeon's performance in terms of complication rate, mortality rate, medical malpractice suit rate, etc. By that time I hope I will be enjoying retirement, since I for one wouldn't want to practice medicine in such an analytical environment which does not recognize the inherent "humanness" of the medical profession.



THE
PITTSBURGH INSTITUTE OF
PLASTIC SURGERY

... where the art of plastic surgery is State of the Art. ...