A surgeon blasts dangerous care, calls for ‘transparency revolution’

Does your OR have a Hodad, a Raptor, or a Shrek? These are handles for dangerous surgeons that Martin Makary, MD, MPH, describes in his scathing new book, Unaccountable.

Dr Makary, a surgeon and patient safety leader at Johns Hopkins, advocates a “transparency revolution” to make data public and motivate physicians and hospitals to clean up their acts.

He also tells about “health care heroes” and promising programs that are making a difference.

The book starts with dramatic stories of bad practice that Dr Makary has seen himself or learned about from colleagues.

Hodad—Hands of Death and Destruction—is a congenial surgeon with a warm bedside manner who’s a disaster in the OR. The Raptor is the opposite, hell on wheels with colleagues and staff but a master of surgical technique. And Shrek is the surgeon the residents dread will be on call in the emergency room.

Then there are the hospitals that the author says cover up bad practice and act like they care more about the bottom line than they do about preventing complications.

Why read the book?
OR managers and directors might think, “Why do I need to read this book? I’ve lived it.”

The reason, Dr Makary tells OR Manager, is that accountability “is one of the defining topics of our era.”

Transparency—the public reporting of data that allows patients to make better decisions—is where he thinks reform lies.

He also points to encouraging stories of “heroes of American health care.” Mark Chassin, MD, pioneered the cardiac outcomes reporting program for hospitals in New York State that has made a difference in patient deaths and complications. He now heads the Joint Commission. Bryan Sexton, MD, fostered development of a widely used safety culture questionnaire that hospitals can use as a barometer of their environments.

Guy Clifton, MD, resigned from Memorial Hermann Hospital in Texas after the administration rebuffed his plans to fix problems behind a high complication rate in the neurosurgery ICU. The cause was taken up by a colleague who refused to take the post until the administration delivered on Dr Clifton’s requests. Today, says Dr Makary, Memorial Hermann is recognized as a top neurosurgery center.

Group efforts
The author also cites group efforts that contribute to better outcomes. The American Board of Internal Medicine’s Choosing Wisely campaign highlights tests and procedures physicians and patients should question.

Dr Makary lauds the American College of Surgeons National Surgical Quality Improvement Program (NSQIP), which measures surgical outcomes, calling its rigorous
protocol the health care equivalent to “landing a man on the moon.”

He tells of hospitals that have had success in addressing disruptive behavior, clinicians and professional groups that are seeking to understand and improve the wide variations in practice, and organizations with cultures that support teamwork and internal error reporting.

He applauds AORN for its campaign encouraging nurses to speak up when something doesn’t seem right.

**Transparency revolution**

If the root cause of all these problems is a lack of accountability, Dr Makary sees transparency as the solution.

“I think public reporting of hospital performance, using the measures professional societies have created, is the best next step,” for surgical quality improvement, he says.

**User-friendly metrics**

He proposes a set of metrics any consumer should be able to look up on any hospital:

- **Bouncebacks**: Percentage of patients readmitted within 90 days by discharge diagnosis.
- **Complication rates** for major treatments and procedures.
- **Never events**: Avoidable events such as retained surgical items, wrong surgery, and death during elective surgery on a healthy patient.
- **Safety culture scores**, such as the staff’s response to the question, “Would you have your operation at the hospital in which you work?”
- **Hospital volumes**: Annual volumes for medical conditions and procedures.
- **Transparent records**, open notes, and video recordings, giving patients streamlined access to written and video records.

**Videos for peer review and for patients**

Sure to be controversial is his proposal to make greater use of video for peer review, monitoring behaviors like use of checklists, and providing patients with information about their care.

Dr Makary says he routinely offers his patients a video of their laparoscopic surgery on a flash drive. He advocates sampling of procedure videos for external peer review and to sample when complications occur.

It’s the same principle as traffic cameras, he says.

“When someone is watching, compliance with guidelines radically improves.”
He challenges colleagues and hospitals to take a transparency pledge that he himself has signed (sidebar).

Dr Makary lures readers in with his horror stories about shoddy care. It’s his way to call attention for his bold message about building a more accountable health care system through transparency.

For OR leaders, the book shows how the volumes of data they and their hospitals are collecting could be the path to greater transparency and better, safer care.

—Pat Patterson