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Caring about the quality of surgical care in Belgium ? Why and how
Opening lecture of the 5th Belgian Surgical Week

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Why ?

The council of our Society has chosen 'Quality of surgical care in Belgium' as the theme of the 5th Belgian Surgical Week in Oostende, May 6 – 8, 2004. The topic may appear to be trivial since we are all convinced that the quality of care that we deliver is the best. My message is that we, surgeons, should stop arguing without hard data. In contrast, we should play a more active role in the implementation of best practice, and in the quality assurance of surgical care. This should not be done by others, but by us in collaboration with others.

It is urgent to act! Our quasi omnipotent Hippocratic or paternalistic position has changed into that of a member in a multidisciplinary team. Instead of opinions, scientific evidence prevails. Post-modern patients request self-determination. Patient rights have been fixed in Belgium by law (22 august 2002) that enumerates the following rights: quality of care, free choice, information, consent, updated medical record, privacy and the right to raise a complaint. Insured health care has been installed in our society, which is mainly consumer driven, expecting quality, transparency and accountability of its health care providers.

Physicians and in particular surgeons have been tackled. As documented by the Belgian Professional Surgical Association, about 1 surgeon out of 12 is confronted with complaints or litigation, mainly initiated by the patient or his family (66%), but also in a relevant number of cases by mutualities. We have also been tackled by writers and journalists that have been called "les chagrineurs d' étouffeurs". The quality of care in hospitals has been criticised by epidemiologists-statisticians estimating that every year about 1500 patients die in Belgian hospitals because of avoidable complications or errors, medical and/or surgical. We have been tackled by health care organisations that will continue to highlight the variability in outcome in different hospitals. Abnormal variability in health care has become unacceptable.

Unacceptable can be called that care that is significantly worse than the national average. Significantly worse is that performance that falls two standard deviations or more to the bad site of the national mean after adjustment for patient and non-patient related factors. Thus, by definition, 2,5 % of us are concerned. But, also a too large standard deviation is being criticised and becoming unacceptable (fig. 1). Remark that average performance (the mean) is not the best. For appropriate corrective actions to be taken, the factors that contribute to poor outcome should be identified, as well as those that contribute to best performance. By the controlled implementation of appropriate action, the standard deviation of the quality of health delivery will decrease and many patients will benefit.

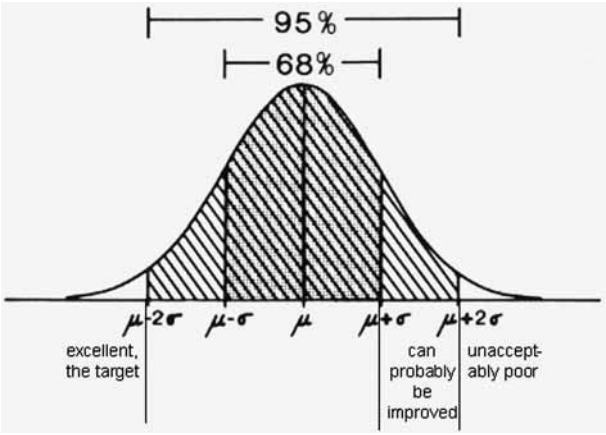


Fig. 1
Variability of care after risk adjustment for patient- and non-patient related factors. The average (m) and its standard deviation (s). Good results on the left of the mean.

How ?

In Belgium, several institutions already exist that set criteria and monitor the prescription of drugs or technical examinations as well as some aspects of the performance of technical procedures. They are the National Council of Quality Promotion, a working group within the RIZIV/INAMI, and the Department of Medical Control. Until now, society and its policy makers have given priority to cost aspects and cost containment. Usually, we consider these institutions as watching 'Big Brothers'. However, we should start to collaborate with these and other institutions, such as mutualities and research units, in order to monitor those data that are more directly related to quality of care.

Data are required. We should stop telling anecdotal case stories, or, in the best case, arguing with our opinion about personal, but unpublished and uncontrolled results. We urgently have to contribute to the nation-wide recruitment of appropriate data, and in particular to their analysis. Doing so, we will more exactly know how we perform and, of greatest interest, what can be the best performance, the target.

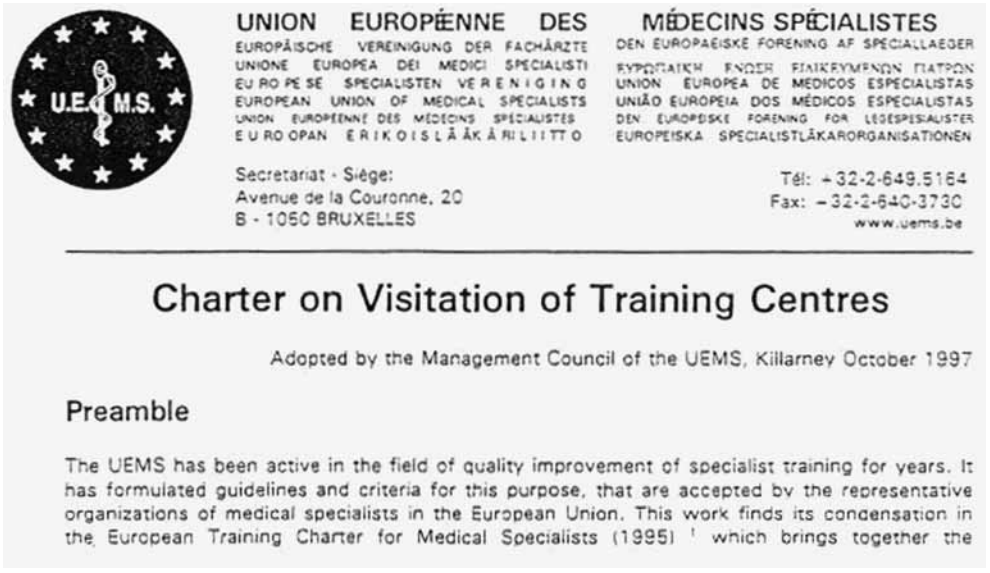
The variation that is the greatest cause for concern is that between actual practice and evidence-based 'best practice'. How to move from good evidence to good practise ? (Fig. 2). We have to update our competence and skills based on that evidence that is relevant for our patients. Based on this knowledge, we can standardise and adapt our practice within the context of guidelines or clinical pathways. Because we all aim to deliver the best quality of care to our patients, no one of us can be against quality assurance. But, we will be demotivated and our behaviour will return to the old one, if our results are not adequately registered and analysed with the help and expertise of our peers and with regular feedback to each of us. Therefore, continuing nation-wide quality improvement projects are required. Surgeons together with many others should be involved. In fact, for the benefit of our patients, there should be no confrontation. In contrast, there should be 'concertation' when we perform in and for our public.

FROM GOOD-BEST EVIDENCE
TO GOOD-BEST PRACTICE
HOW ?

- updated competence and skills (Continuing Medical Education + Continuing Professional Development)
  - standardisation (with flexibility)
    - guidelines, clinical pathways
  - implementation
- monitoring = quality assurance
  - nation-wide registration
  - analysis (peers) + feedback
  - nation-wide quality improvement projects
- motivation

Fig. 2

Updated knowledge is essential. Your Society of Surgery is setting up an E-library containing relevant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Charter on Visitation of Training Centres

Adopted by the Management Council of the UEMS, Killarney October 1997

Preamble

The UEMS has been active in the field of quality improvement of specialist training for years. It has formulated guidelines and criteria for this purpose, that are accepted by the representative organizations of medical specialists in the European Union. This work finds its condensation in the European Training Charter for Medical Specialists (1995) [1] which brings together the

Fig. 3
Charter on visitation of training centres, published by the UEMS in 1997.

international journals for his membership. Evidence published should be read, and discussed e.g. within the sections and committees. Each of you can also contribute to and evaluate guidelines. For example, multidisciplinary guidelines on rectal cancer are available on www.belsurg.org/imguplo ad/BSCRS_/guidelines%20rectal%20cancer.pdf. Read and comment them because they are the basis for a nation-wide project supported by all involved scientific societies and the Belgian Professional Surgical Association. I would like to further stimulate all sections of the Surgical Society and its affiliated or sister societies, to set up more prospective randomised clinical trials, so that all of you are able to contribute to relevant surgical evidence.

I also would like to promote more intense and formal collaboration between the Royal Society of Surgery and the Belgian Professional Surgical Association. Indeed, if both would collaborate in concert with all those providing care to our patients, as well as with health care managers and administrators or policy makers, better national registers and projects could be set up.

Finally, the quality of training of the future surgical generation should be assured and improved. Seven years ago, the Union Européenne des Médecins Spécialistes published a very adequate 'Charter on visitation of training centres', adopted by the Management Council of the UEMS in Killarney, October 1997 (Fig. 3). I really hope and wish that the Belgian Association of Surgical Trainees, in collaboration with their trainers, the Surgical Society and the professional association, will contribute to the realisation of visitation and objective audit of surgical training and training centres. Again, like with the evaluation of the quality of care, the primary endpoint should not be to stigmatise or exclude a specific training centre. Instead, outliers have to be informed. They should be given the instructions to be taken in order to improve their performance, based on the characteristics and actions taken in the best training centres.

Conclusion

Times have changed. We became members of multidisciplinary teams. For sure, we will not loose our surgical identity or personality. But, we have to score now, and why not, more and better than the others ! Therefore, this 5th Belgian Surgical Week is dedicated to all of you, potential pioneers in surgical quality care improvement. Indeed, I most sincerely hope that this meeting will stimulate each of you to contribute to and participate in quality of care projects.