From the Society for Clinical Vascular Surgery

Look, listen, and feel

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Being president of the Society for Clinical Vascular Surgery has been the highlight of my career. I know of no words that can accurately express my deep gratitude to all of you for the privilege to serve as your president.

I wish to acknowledge several surgeons who have been extremely influential in my development.

Dr Wiley Barker was one of the early pioneers in vascular surgery. He served as a role model and became a friend. His mellow personality was inspiring and very different than most surgeons I knew or have known since. Wiley and his beautiful wife, Nancy, passed away recently, and I miss them.

Dr Wesley Moore, my mentor, has been instrumental in my choice for an academic career. He taught me that a busy clinical practice can be part of a productive academic track. When I saw him present at meetings, I knew it was coming from an outstanding practicing surgeon. He is a true gentleman.

I want to thank Dr Ronald Busuttil, the best surgeon I have had the privilege to operate with, for his support over the last 30 years, including the last 12 years as Chairman of the Department of Surgery at UCLA. It is based on his determination, hard work, and clinical skills that UCLA has the best and largest liver transplant program in the world. It is because of his support that we have an Aortic Center at UCLA.

A DOCTOR VISIT IN 2017

For the last 2 years, I anticipated this moment and must confess that deciding the topic of this address has occupied increasing space in my mind. I considered presenting several illustrative patients' stories, some tragic, some funny, but all interesting. For example, some years ago, I saw the patient with an abdominal aortic aneurysm referred by his primary medical doctor. During the visit, I complimented the referring physician, saying, "It is great that your doctor examined you and found this aneurysm." The patient looked at me with wide open eyes and said, "Oh no, that was not how it happened. We were sitting across from each other and were basically done with the visit. He was trying to find my pulse at the wrist but was having difficulty. I told him that it was much easier to find in my belly" (Fig 1). There are a few other stories, but I figured we all have some.

Then I had a brilliant idea. I will talk on… how to make vascular surgery great again. Unfortunately, the concept was taken by someone else last year.

Recently, I was at a strategic planning committee meeting at my institution trying to contribute in some way, on and off pondering what I should talk about at the Society for Clinical Vascular Surgery. I'm not much of a committee person, always remembering how a camel came to be: a horse designed by committee!

I kept trying to pay attention to the deliberations, hearing terms such as service line, throughput, the metrics, contribution to margin, profit margin, capture area, market strategy, and target population. Someone mentioned risk management. Have you ever thought whose risk is being managed?

I kept thinking, where is the patient and where is the doctor in all this? It must be said the committee helped me that day more than whatever I contributed to the discussion.

Consider the description by Dr Nortin Hadler in the book *By the Bedside of the Patient*[1] of what a doctor visit is today:

> Going to the doctor today is not your grandfather's experience. In all likelihood, you park in a deck, walk through a marble lobby, and report to someone behind a counter who is pretending to make your approach anonymous. Then you'll take a seat and wait to be called for "intake": questionnaire, vital signs, review of medications delivered to the back of the head of the intaker, usually a nurse, as he or she hovers over the computer. You may wait in the lobby further until called into your doctor's examining room.
>
> The greeting is warm, cordial, and brief before he or she turns away to also hover over the computer. Care of the patient in the current system demands attention to the requirements of the electronic health record; much must be entered and given time constraints, much

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needs to be entered in real time. Many institutions are providing their providers with assistance in the form of "scribes" who do the entering into the appropriate places demanded by the program as the information is elicited. That preserves a vestige of eye contact. It might seem that you and your doctor are in the room to serve the entry of data. It might seem so because it is nearly so.

This is the current approach to clinical practice. In the last 20 years, the ratio of administrators to physicians has grown by more than 3000% (Fig 2). It is therefore not surprising that most of the health care dollars go to others and not the providers. Less than 20% of expenditures in health care are allocated to providers, while more than 50% goes to administration. Underscoring the point is that more than 50% of the nurses in the United States are now administrators and do not provide direct patient care.

THE ELECTRONIC MEDICAL RECORD

Let's look at the evolution of the electronic medical record. The concept was great. A medical file that would contain all the critical information available for use anytime, anywhere the patient needed it. We were told that this would save time, have significant financial benefits in addition to health benefits by being able to share records that were easily accessible. It would also have environmental benefits by saving a few trees.

Instead, it has morphed into a massive bureaucratic instrument. Important clinical information is buried in a document where copy and paste creates unnecessary duplication, and not infrequently errors are repeated. Have you seen a how a simple headache can become so complicated with the need to describe it (Fig 3), with never ending entries way beyond what is clinically relevant?

The electronic medical record today best serves the enterprise as a billing tool and the government to monitor provider activity. The latter requires filling in blanks to demonstrate "best practices," which burdens physicians and only affects patient care by decreasing the time and attention they receive from the doctor.

IS THIS REALLY A WAY TO PROMOTE BEST PRACTICES?

Regulations for the electronic health record demand that a meaningful use document be handed to the patient after the visit, as if this would indicate meaningful care. Add to the current system the movement to base treatment decisions on statistically proven data referred to as evidence-based medicine, not recognizing that statistics embody averages, not individuals.[1]

Edwards Deming, a PhD in physics, proposed that focusing on quality increases productivity and thus reduces cost, while focusing on cost does the opposite. In 1987, Bill Smith, also an engineer, took this concept further with the Six Sigma approach: all aspects of production, even output, can be reduced to quantifiable data, allowing the manufacturer to have complete control of the process. Such control allows collective effort and teamwork to achieve the quality goals. Without question, this can result in improvement of quality and profitability of a multitude of products, from automobiles to engines and cell phones. Every product is the same, well designed and built, and each is predictably profitable. "If patients were widgets, if caregivers were production workers, and if caring conformed to Six Sigma principles, errors would be easy to recognize, those responsible for the failures could be singled out for improvement, and remedies would be obvious."[1]

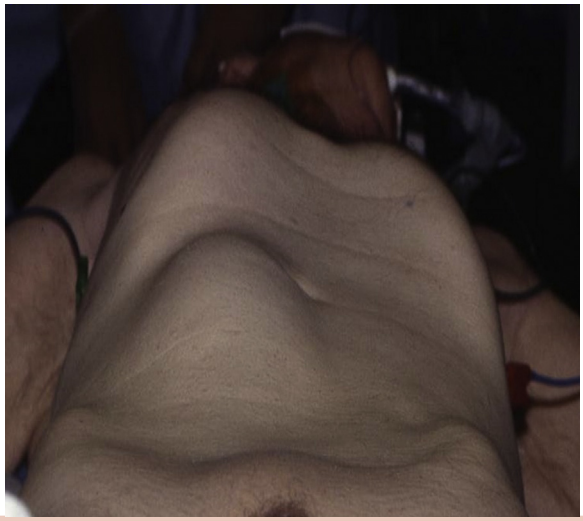

Fig 1. Looking for the pulse: "I told him that it was much easier to find in my belly."

Defining efficiency as the care given per patient per unit of time demands an assembly line. No clinical metric conforms to a Six Sigma standard. "In medicine and surgery, we are comfortable defining normal with a 95% confidence interval and we are fully aware that outliers can be clinically normal and those in the normal range, abnormal."[1]

Unfortunately, we cannot go back. We must deal with reality and try to minimize the impact of the current trends. Patients must remain at the center of clinical activity, and we must be the guardians to ensure that this is the case.

THE DOCTOR AND THE PATIENT

The relationship between the doctor and the patient is being eroded by several factors. To begin with, it is unnatural and poorly understood by the administrative class of the health care system. The doctor-patient relationship is unique. Consider what it represents: an intimate voluntary interaction between two human beings who just met. In a sober state, when else do you disclose detailed confidential information to someone else without a prior relationship? Administrators fail to recognize that such