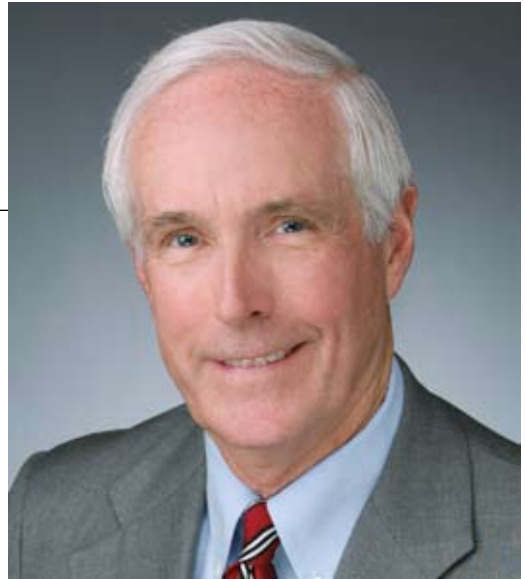


From my perspective



The movement toward value-based, patient-centered care could have revolutionary effects on surgical and medical practice. Surgeons and other physicians will be expected to report information about themselves and their practices to patients, insurers, the government, and their representative boards and organizations. These data most likely will be used for credentialing purposes, to aid in making health care decisions, and to determine reimbursement. To ensure that meaningful information is collected and analyzed and that the data are used sensibly, medical and surgical associations are working collaboratively, both within the house of medicine and with external stakeholders.

In the past, many organizations had adversarial relationships with each other and with government agencies. Although taking opposing positions allowed each association to maintain its own identity and attract a specialized membership, this approach failed us and our patients on many broader levels. Most significantly, we were unable to communicate with one voice our concerns about government efforts to reform the health care system and control spending. As a result, organized medicine was rarely asked to sit at the negotiating table, and we wound up with an inadequate system.

If we want to participate in the design of safer, more coordinated patient care, we cannot operate in isolation. Hence, in recent years, the American College of Surgeons has sought to solidify its relationships with the American Medical Association (AMA) and with the alliances responsible for vetting quality performance measures for surgery.

The AMA

In the 1970s and 1980s, the American College of Surgeons and the AMA had a tenuous relationship. In fact, in 1980, we withdrew from the AMA House of Delegates (HOD), leaving surgery with no official representative in this politically powerful organization. This void was filled after College staff met with the surgical caucus of the HOD on several occasions, a process that culminated in the 1992 appointment of a delegate and an alternate delegate to represent the American College of Surgeons. Since then, our delegation

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has grown to four delegates and one alternate, who have successfully promoted resolutions on subjects of surgical interest and encouraged the AMA to take action on issues of relevance to surgery. In addition, College staff now provide support for the surgical caucus, and Richard Reiling, MD, FACS, serves on the AMA's Council on Graduate Medical Education. Dr. Reiling was the first College-sponsored candidate for election to an AMA post.

As the article on page 13 notes, William G. Plested III, MD, FACS, was recently inaugurated as AMA president. A thoracic and cardiovascular surgeon from Brentwood, CA, Dr. Plested brings to this position a thorough understanding of the issues directly affecting surgery at this time. Several other Fellows have served as president of the AMA in the past, including, most recently, Donald J. Palmisano, MD, FACS, of Metairie, LA.

Furthermore, for the last several years, ACS Fellow Michael Maves has been the AMA's execu-

tive vice-president and chief operating officer. Dr. Maves has infused the AMA with a new enthusiasm for addressing issues from the perspective of the spectrum of medical and surgical specialties and for collaborating with their representative organizations.

Quality consortia

It is important to note that the AMA also is playing an active role in helping to develop quality performance measures for physicians through its Physician Consortium for Performance Improvement. To some extent, this panel represents the first stop for these metrics on the route to endorsement and implementation. This consortium has a perioperative care workgroup, and R. Scott Jones, MD, FACS, Director of the College's Division of Research and Optimal Patient Care, co-chairs that workgroup. The perioperative care workgroup has developed performance measures for cardiac risk assessment and is now finalizing measures related to antibiotic and venous thromboembolism prophylaxis.

Once the AMA consortium has approved performance measures, it sends its recommendations to the National Quality Forum (NQF), which seeks to validate the measures for use in public reporting. Since 2000, the NQF has promulgated more than 200 quality measures for all types of medical care and is now looking to develop measures that account for the unique nature of surgery.

Meanwhile, the AQA (formerly the Ambulatory Quality Care Alliance) focuses on outpatient treatment and recently formed the Surgery/Procedures Performance Measurement Workgroup. The workgroup is chaired by Frank G. Opelka, MD, FACS, and is composed of representatives of societies serving all members of the operative team, including anesthesiology, in addition to the range of surgical specialists. AQA and its subgroups address the implementation challenges surrounding quality measurement and is a source of information for the Centers for Medicare & Medicaid Services, the federal agency likely to require quality measurement and reporting in the future, as well as private insurance plans.

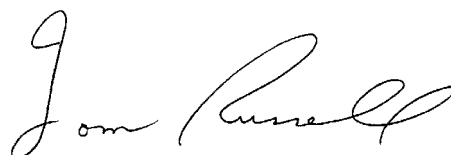
In 2005, the surgical community formed the Surgical Quality Alliance (SQA) to pool resources to more effectively coordinate multiple quality initiatives. The College continues to manage

the SQA, chaired by Dr. Opelka, which currently includes 20 surgical specialty societies and anesthesiology. The SQA works to improve the quality of care for the surgical patient, to define the principles of surgical quality measurement, and to develop awareness about issues related to surgical care and quality. Perhaps most importantly, it provides a forum for successful collaboration among surgical specialty societies in pursuit of a common goal.

Because these alliances are likely to affect patients' understanding of which providers and professionals offer the best possible care, as well as a primary care physician's ability to refer patients appropriately, the American College of Surgeons considers its involvement in their activities vitally important.

Making a difference together

The College anticipates that by continuing its involvement in the increasingly robust and collegial AMA and by playing an active role in the alliances that are promulgating quality measures, we can do a better job of ensuring that patients receive quality care in the future. The time for quibbling over differences of opinion and for asserting our independence is long passed. We need to focus on how we can create a quality-based, patient-centered health care system. This effort is going to require patience and outreach, but together we can make a difference.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.