“Comparing Notes” is a readers’ column devoted to sharing information on problems associated with aesthetic surgical procedures. Readers can share experiences, submit questions, and aid in finding solutions by writing to: John G. Penn, MD, editor, Aesthetic Surgery Quarterly Forum, c/o ASAPS Communications Office, 444 East Algonquin Road, Suite 110, Arlington Heights, IL 60005. Please limit submissions to 300 words. Those submitting questions may suggest a surgeon from whom Aesthetic Surgery Quarterly might request a response, or Aesthetic Surgery Quarterly will make the selection. Names of individuals submitting problem cases will not be published. Submissions are subject to editing.

Outcomes Studies and Aesthetic Surgery

What are outcomes studies and what have they to do with aesthetic surgery?

Bruce L. Cunningham, MD, Minneapolis, MN, discusses outcomes studies and their use in aesthetic surgery.

The outcomes study is a medical information tool that health care payers hope will enable them to make better decisions about purchasing health care services by statistically defining value in the medical marketplace. Its origin was driven by the need for competitive, market-mediated health cost containment. The outcomes study serves both as an index to the relative effectiveness of different treatments and as a monitoring tool to detect and remedy potential deterioration in the quality of care resulting from overzealous rationing of resources by managed care providers. Today, outcomes studies are increasingly viewed by policy makers as a mechanism to ensure a minimum quality of care rather than to stimulate and reward excellence. The defining equation of the outcomes movement is Value = Outcome/Cost. Note that restrictions in cost may not provide incentive for true excellence in quality of care.

To a large degree, the emergence of outcomes studies was a logical response by payers to the wide and seemingly illogical variations seen, both nationally and regionally, in physician practice patterns. With such variance, it became essential to determine which therapies were of greatest worth and value and to establish guidelines that would direct all medical practices toward recognized and accepted standards. Competing individual practices would have to provide data that would allow comparison with the established benchmark values. Dr. Paul Ellwood, recognized as the progenitor of the outcomes movement, ascertained the need for medicine to establish a “central nervous system” that could integrate the complexities of modern medicine.

The very definition of outcomes studies has been shifted by this change in the vantage point of measurement. In the past, the physicians alone defined outcomes, measuring the result in clinical parameters of interest to them. However, in the new marketplace, “counting the dead is not enough,” and new measures that record dimensions of outcomes that are more patient- and consumer-oriented have been deemed essential. Capturing the “view from the bed” is a vital component in determining value in the marketplace because it asks “consumers” to assess the global dimensions of their health: physical and psychologic functional status, sense of well-being, and satisfaction with the quality and delivery style of care.

Tools and Methods

The tools and methods of this new data-collecting discipline are different from those that were available in the past. The classic model for clinical assessment, the double-blind controlled study, is deficient because it collects data in the rarefied atmosphere of the research center and does not reflect medicine as it is really practiced. New study instruments are standardized to reliably capture the global dimensions of health care across a diverse population and have had to be readily integrated within the context of the average physician’s practice style.

In addition to capturing such data as patient satisfaction, well-being, and functional status, which are common to most outcomes studies, instruments are designed to identify specific parameters of the particular disease being studied. Thus an outcomes study assessing breast reduction would include a standardized measurement of general health status, such as the Rand SF-36, and a battery of questions related to the consequences of massive breast size. After surgery, the patient would again be assessed to determine the benefit versus the cost of the intervention.

The consumers’ appraisal is intuitively obvious to aesthetic surgeons who are used to having their value set
directly in the marketplace. It is clear to us that patients benefit from aesthetic surgery in many intangible, but extremely important ways, and it is an advantage for us that the marketplace is learning to quantify these parameters. Does our unique identity within the mosaic of medicine, however, allow us to disdain outcomes studies?

**What Do Outcomes Studies Have to Do With Aesthetic Surgery?**

Aesthetic surgeons must take note of the outcomes movement as it presages three trends in medicine that will impact increasingly on the future of our specialty. First, most of us are not in a position to ignore the forces of managed care. We must validate common procedures such as breast reduction, corrective rhinoplasty, blepharoplasty for visual field obstruction, and many others so that they remain reimbursed procedures within our practice. Once participating within the managed care world, we will be compelled to measure our own practices against established benchmarks for procedures we perform. These benchmarks will be established by others if we ignore the trend.

Second, aesthetic surgeons who have outcomes data will be in the best position to demonstrate their value directly to consumers in the face of competition from other providers of aesthetic surgical services. The ability to present data to demonstrate patient satisfaction, quality of care, cost-effectiveness, and the other parameters that outcomes studies can measure will provide factual distinction of our abilities. Viewed as a commitment to intelligent marketing in the age of information, validated outcomes data will reassure the consumer in a format they have become accustomed to.

Finally, we cannot assume that our sanctum of purely aesthetic procedures will be neglected by the forces of managed care. Managed care plans need to distinguish themselves. In some regions providing “premium service enhancements,” such as fertility therapy, psychologic care, health club enrollment, and other services, at reduced rates to subscribers have been discussed. Can “premium” aesthetic surgery services be far behind? With the overabundance of providers available and willing to work, payers will find a source for “discounted aesthetic surgery services.” Despite our desires and tradition, we will have to provide outcomes data to compete for a share of these contract services or risk being supplanted by others.

Most aesthetic surgeons have more experience than they realize with the outcomes study that reaches beyond the simple “patient satisfaction” or “physician satisfaction” tools of recent years. The efforts to validate the benefit of saline and silicone implants are a paradigm for incorporating outcomes discipline into current practice patterns. Organized plastic surgery has developed or appropriated several outcomes instruments that will soon be available nationally. In the future, participation in outcomes activities will represent the most intelligent tool for assessing, promoting, and marketing the value of our services.

Reprint orders: Mosby-Year Book, Inc., 11830 Westline Industrial Drive, St. Louis, MO 63146-3318; phone (314)453-4350; reprint no. 70/1/72809