

Good Help, Close to Home

By Betsy Querna and Josh Fischman
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The renowned Mayo Clinic in Rochester, Minn., isn't that far from Mauston, Wis., where Don Wilke lives--only about a 2 1/2 hour drive. But when the 51-year-old bricklayer needed hip replacement surgery last March, he didn't need to make that trip. He went instead to a small hospital in Viroqua, Wis., a little over 50 miles away. Wilke was walking within days after orthopedist Jeffrey Lawrence implanted a metal joint in his left hip, and after a month he was feeling spry enough to make his annual spring turkey-hunting trip. "It's night and day," he says. "Before, when I came home from work, I just sat down. Now I can go out to the woodshop, garden, mow the lawn, or do whatever."

As Wilke and millions of others have learned, community hospitals can be just as good for some patients, even for those who need serious attention, as any glittery big-name center. "There's a lot of community hospitals that deliver excellent care," says David Flum, an associate professor of surgery at the University of Washington School of Medicine in Seattle who studies surgical outcomes. But not all community hospitals offer good care for all conditions. How can you tell whether a local hospital is right for you or when you should pack your bags? By getting information relevant to your illness or procedure, say Flum and other experts, about the hospital's performance and the doctor's experience.

Another name for community hospitals is primary-care facilities--a first stop for medical and surgical help, with few or no ties to academia or research. They are the mainstays of American hospital care. Of more than 35 million patients admitted in 2004, about 85 percent were to a community facility. That is where most hip and knee replacements, appendix removals, and some colon and prostate surgeries are now done. And like those in other demanding careers, many fine physicians who work in community hospitals do so because they traded big-city bustle and academic stress for a lower-velocity life.

Many people prefer local care, and there are measurable medical benefits from having family and friends close at hand. Studies show that people who have just had open-heart surgery have less pain and are quicker to get out of bed when they feel supported by others. "They just emotionally feel better if they have someone they could rely on," says Kathleen King, a professor of nursing at the University of Rochester's School of Nursing and author of one such investigation. "It's the day-to-day stuff that really helps people recover."

Obtaining the kind of information that experts like Flum want you to have probably won't be a snap. California, Maryland, New York, Pennsylvania, and Texas are among the handful of states that do put performance data about individual hospitals for some procedures, such as heart bypass surgery, on state health department websites. Many of the links to such sites are available at healthcarechoices.org for free. A \$15 hospital performance report can be purchased from HealthGrades.com, but evaluations for procedures and conditions are in the

form of broad star ratings rather than numbers. And while some community hospitals do appear in the "America's Best Hospitals" rankings--a tribute to their quality--primary-care centers are not the main focus.

Do-it-yourself project. For the most part, then, you'll have to do your own data gathering. A good place to start is with a principle that has generated stacks of medical studies: Practice may not make perfect, but it helps--a lot. "If a patient had to pick a single factor on which to choose a hospital and pick a surgeon, they would do better to focus on volume and experience than anything else," says John Birkmeyer, a professor of surgery at the University of Michigan Medical School who has produced a fair share of the stacks himself. Doing a high volume of procedures hones a surgeon's skills, makes the operating room team more efficient and less error prone, and encourages hospitals to think harder about postoperative care and rehabilitation strategies.

The caveat is that while everyone agrees more is better, there is little agreement about just how many are enough. For a few procedures, studies have found evidence that argues for annual minimums (table, Page 78), and Medicare and some commercial health insurance plans require them in some cases. But many hospitals are at the low-volume end, and most procedures don't even have guidelines. For a particular one, you can ask several hospitals how many the busiest surgeon does annually, but the answers may still leave you wondering whether the number you were told is sufficient. You'll probably need to ask follow-up questions, probing for information on other quality measures.

Death and complication rates are the ultimate bottom line. But these numbers often are unavailable, and it isn't always obvious whether a good number means a good surgeon or just one who's had easier cases. The best approach is direct and personal, asking: What is your death rate at this hospital for this procedure? What is the complication rate? What are the rates for a patient like me? For prostate cancer, "I give patients names of my last 10 patients of similar age and stage of disease," says urologist James Eastham of Memorial Sloan-Kettering Cancer Center in New York. "If I just operated on 50-year-olds, my potency rates would look great," he says. "But if you're 72, that's not going to apply to you."

Posing such questions also offers an opportunity to test comfort level. Any physician should be willing to talk frankly about outcomes, various medical alternatives, and his or her own training and experience. If the reaction to such questions is vague or hostile, says Flum, "walk away."

Volume unequivocally matters in heart surgery, so *U.S. News* found a hospital in Texas that shows how patients can exploit that to find good local care. For hip replacement, a small Wisconsin hospital exemplifies how other quality measures can guide patients to good surgeons. And two hospitals--one in Ohio and one in Pennsylvania--demonstrate the complex choices involved in treating prostate cancer.

EXPERIENCE COUNTS

The south Texas border town of McAllen does a brisk business in heart surgery. Surgeons at McAllen Medical Center performed just over 800 bypass operations in 2003--fifth highest in the state--and did them well. The mortality rate, adjusted for the severity of patients' conditions, was 1.2 percent, less than one-third the state average of 4 percent. "I do a better job on these patients in my community hospital than I did when I was training in my university hospital," says McAllen's Lester Dyke, a cardiac surgeon who does between 500 and 600 of the procedures a year and cites a mortality rate of about 1 percent.

There's a strong link between volume and quality for coronary bypass surgery. There's also a fair amount of disagreement over the definition of high volume, although both McAllen and Dyke would satisfy any of the proposed numbers. The Leapfrog Group, a standard-setting consortium of large employers, puts the bar at 450 hospital surgeries annually. A large study published in *Circulation* in 2003 found that mortality risk is 29 percent lower in hospitals where at least 600 bypasses a year are performed by surgeons who do 125 or more than when neither the hospital nor its surgeons meet those volume thresholds.

Still, the line is blurry, say most researchers, and surgeons who perform fewer than these recommended numbers should not automatically be assumed to do them worse. "There's very little difference between a surgeon who does 300 versus 100," or even 50, says Fred Edwards, chair of cardiothoracic surgery at the University of Florida College of Medicine in Jacksonville and chairman of the Society of Thoracic Surgeons' national database of cardiac surgery outcomes.

THE BEST HIP JOINT

Vernon Memorial Hospital in Wisconsin, where Don Wilke had his hip replaced, highlights volume's slipperiness as an indicator of quality. The 25-bed hospital had no real orthopedic program until surgeon Jeffrey Lawrence moved his family from the tony Chicago suburb of Highland Park to the 4,000-person town. Now Lawrence *is* the program. He does about 80 hip replacements each year, which puts the hospital short of the 100 recommended by several studies. It is considerably above the suggested individual physician benchmark of 50, however.

Lawrence's hip joint patients also have an impressively low rate of infections--0.25 percent against a national average of 1.5 percent. Infection after joint replacement is a complication that prospective patients should always ask about, because the consequences, such as more surgery to replace the infected joint, can be serious. All surgeons and hospitals should know their infection rates and should be willing to discuss them, says Paul Pellicci, an orthopedic surgeon at the Hospital for Special Surgery in New York City. "That's data that every hospital has. If they say they don't know, it's either because they don't want to tell you or they don't think you have the right to ask the question."

Besides board certification in orthopedic surgery--a must when considering any major orthopedic operation--Lawrence did a post-residency fellowship in joint replacement, a strong indication of competence. Vernon employs physical therapists who work closely with the orthopedic department, something doctors say helps ensure that patients receive proper care in recovery.

JUGGLING THE PROSTATE OPTIONS

Prostate cancer presents two issues: where to go and what to do. The two main choices are radiation or surgery. The radiation options are either external beams directed at the cancer or radioactive "seeds" implanted in the prostate. Surgery involves removing the prostate, or radical prostatectomy. About two thirds of patients opt for radiation.

That's what John Paul McMahon picked--specifically the seeds. The 68-year-old Franciscan friar lives in tiny Steubenville in eastern Ohio. Three years ago his level of prostate-specific antigen (PSA, measured by a blood test as an early warning of prostate cancer) began shooting up, and his doctor took snippets of prostate tissue. "I was shocked at the biopsy results," says McMahon. "And worried. Cancer is a scary thing." The good news was that his

disease was confined to one part of his prostate. McMahon drove an hour away to the University of Pittsburgh Medical Center, where a surgeon told him he was an excellent candidate for a prostatectomy.

But Trinity Health System, the major source of hospital care for the area, had recently geared up a state-of-the-art seed implant, or brachytherapy, program. Trinity's radiation oncologist, Mark Trombetta, was affiliated with Allegheny General, a major medical center in Pittsburgh, and had assembled valuable new technology: ultrasound scanners to image the prostate and an advanced computer program to instruct Trombetta while he was in the operating room exactly where to place the seeds to hit the cancer but spare normal tissue.

"Boy, did I pray," says McMahon. "And I decided on radiation. Prostatectomy is routine, but it's still major, and there's some potential for incontinence and impotence afterwards. And I had great, great confidence in Trombetta."

A good team. McMahon knew Trombetta's record. By now, he has done over 200 brachytherapy cases at Trinity, with just one disease recurrence. That's identical to the rate at Allegheny General. And Trinity does about 25 a year, enough volume to produce good outcomes.

McMahon went in the morning of Oct. 22, 2003, went home that afternoon, and was back at work a few days later. His PSA gradually fell from 4 to a healthy 1. "I trusted in God, and I trusted in my doctors, and that's truly a good team," says the friar.

If McMahon had opted for surgery instead, he would have had to mull over Trinity's record of only two prostatectomies per year. For an operation in which more means better, that's low for any hospital. A typical urologist does 11 to 12 a year, says Peter Carroll, chair of urology at the University of California-San Francisco. "I think that doing between 20 to 30 of these each year makes you an experienced surgeon," says James Eastham, who researches prostatectomy outcomes. In several studies by Eastham and others, patients of surgeons who do fewer than 20 operations per year have a 10 percent to 30 percent higher rate of incontinence or impotence than do those whose surgeons do more than 33. "Those are real big differences," Eastham says.

Patients who elect surgery don't always need a Sloan-Kettering or a UCSF, where urologists do three or more a week. Paul Sieber, chief of urology at Lancaster General Hospital in Pennsylvania, averages about 50 a year. "We participate in a national database of more than 100 urologists," he says, "and our outcomes--continence, potency, and cancer recurrence--are at or above the average."

Still, advanced prostate disease or other challenging conditions may overmatch even good community hospitals. The more rare the diagnosis or the more difficult the procedure, the better off you'll be at a major referral center. Most of the time, however, your best choice could be just up the road.