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FROM THE DESK OF THE PRESIDENT

Technology Assessment in an Age of Accountability

How many of you are confused about exactly what the state of the art or science is relative to the use of things like IDET, rhBMP-2, cages, vertebroplasty, kyphoplasty and/or various minimally invasive approaches to surgery? If we don't use a certain technology, might we be accused of practicing below the standard of care? Where do we go for these answers?

Recently, the NASS Board decided to become more involved in technology assessment in order to give better guidance to the membership about the state of the science for various technologies. Though this makes some of us nervous, because it brings us closer to the nexus between industry and patient care, it is a very important endeavor for the society. NASS already publishes *Current Concepts* reviews, position statements and clinical guidelines.

One thing is certain, NASS needs to do this assessment in a way that is above reproach. We have to be diligent that the PROCESS we use to come up with any statement relative to any matter is based on objective, thorough review of the scientific literature and any other pertinent data. Any review we conduct should be at the direction of our Research Council and should be done by wholly independent reviewers (people who have no connections to the matter being reviewed). This will help us to ensure that the review process is unquestionable. Keep in mind that the essence of objectivity is knowing that you are subjective. So, if we rely on members with no connection to the issues, the results will have the highest possible credibility.

Accountability is as prominent in the news these days as is health care. Corporate scandals and corrupt CEOs make as good a headline as a doctor who is being sued for malpractice. The Sarbanes-Oxley Act of 2002 (Public Law 107-204), recently passed by the 107th Congress, essentially states that there is a corporate responsibility for accurate financial reporting. Specifically, it is up to the principal executive officer (or officers) to certify in each annual or quarterly report that:

(1) the signing officer has reviewed the report;

(2) based on the officer's knowledge, the report does not contain any untrue statement of a material fact;

(3) the financial statements, . . . fairly present in all material respects the financial condition and results of operations of the issuer.

If these requirements are not met, the CEO, or principle officer, can be fined and/or go to prison for up to 20 years. It is unfortunate that the Enron scandal and other similar problems have led to the need for this new law. However, it reflects the public's growing impatience with those who manipulate data to achieve personal gain. Another example of this increasing accountability exists in NASS' new Professional Conduct Program. (See January/February 2003 *SpineLine*, pages 35-38 for details about the NASS Professional Conduct Program.)

Law can be described as the minimally acceptable form of behavior. So now, in the corporate accounting world, there is a new low bar to hurdle. Common sense tells us that there should have been no need for this law, but corporate misbehavior has mandated otherwise.

So what can we learn from this? My suggestion is that we look away from this new low legal standard toward a much higher ethical standard. If "law" can accurately be described as the minimally acceptable form of behavior, can "ethics" then be described as the most desirable form of behavior? If the answer is "yes," then aren't we better off trying to focus on the most desirable forms of behavior in all our activities?

As a nonprofit national medical society, NASS' mission is to advance quality spine care through education, research and advocacy. Our technology assessment activities can help us in each of those areas. How many of you are confused about exactly what the state of the

art or science is relative to the use of things like IDET, rhBMP-2, cages, vertebroplasty, kyphoplasty and/or various minimally invasive approaches to surgery? If we don't use a certain technology, might we be accused of practicing below the standard of care? Where do we go for these answers?

At a recent dinner, I was reminded by some of NASS' elder statesmen that NASS was initially founded to help the members wrestle with difficult patient care questions. We have grown so much over the last 10 years, and are going in so many different directions now, that I think this was a good reminder for us. Essentially, we exist to help members deliver optimum patient care. There is so much competition for podium time at the NASS annual meeting that we can't be sure we are delivering the same value today to the membership that we were delivering 10 years ago. Our symposia are consistently rated the highest at the annual meeting and this is likely because we gather the best experts we can about a particular topic, regardless of their specialty, and then ask them to share their experience and wisdom with the field. This is the essence of what NASS is about.

The NASS Board feels that the membership needs guidance on newer technologies in particular because there are so many questions and limited information. Thorough review of any technology helps us determine the state of the science in the literature and in some cases can give indications where more research is needed. And finally, if there are good reasons, NASS can and should strive to get CMS to reimburse for certain technologies. We will begin a new conference in 2004 that focuses on emerging technologies so that we can be sure we are helping members with questions they have about these technologies.

Technology assessment is nothing new but it seems to have taken a back seat to other pressing concerns in the association community. Several organizations used to perform technology assessments regularly, but these evaluations seem to be few and far between these days. Why have they given it up? Many reasons are possible. They are difficult to do. They take time and

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resources. But just because something is hard to do should not stop us from doing it. If we don't do it, who will? If we let others define the field for us, do we have anyone but ourselves to blame?

Within the Department of Health and Human Services (HHS), a variety of groups, including NIH, are producing evidence reports, technology reviews, technology assessments, clinical practice guidelines and consensus reports. All of this information funnels to CMS to assist it with payment decisions. There is a group within the Agency for Healthcare Research and Quality (AHRQ) that is charged with performing technology assessments. This group often flies under the radar and so many of us do not know it exists or what it does. According to its Web site:

The technology assessment program at the Agency for Healthcare Research and Quality (AHRQ) provides technology assessments for the Centers for Medicare & Medicaid Services (CMS). These technology assessments are used by CMS to inform its national coverage decisions for the Medicare program as well as provide information to Medicare carriers.

AHRQ's technology assessment program uses state-of-the-art methodologies for assessing the clinical utility of medical interventions. Technology assessments are based on a systematic review of the literature, along with appropriate qualitative and quantitative methods of synthesizing data from multiple studies.

Technology assessments may be done in-house by AHRQ staff or they may be done in collaboration with one of our Evidence-based Practice Centers.

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field, others will do it for us. We have not been active in assessing technology and it is important that we become a reasoned voice in this area. Others have examined how technology assessments should be conducted. The American Medical Association Policy H-480.984 "Technology Assessment in Medicine" provides some of the following selected guidelines:

(a) The primary objective of health care technology assessment should be the development of accurate and complete information for physicians on safety, effectiveness and clinical indications in order to enhance the appropriate utilization of health care technology.

(f) Health care technologies should be re-evaluated on a continuing basis after their introduction, particularly if they are expensive or have the potential to cause serious harm if applied inappropriately.

(g) Obsolete technologies should be identified and their further use should be discouraged.

(h) Cost-effectiveness is an important consideration in technology assessment, but it should remain subordinate to considerations of safety and effectiveness.

(j) Payor determinations regarding coverage for health care technologies must be made with the involvement of the medical community and the public. Such determinations should be timely and responsive to the evolving information on safety and effectiveness.

The AMA guidelines do help us to consider what needs to be accomplished and some of the factors that go into it. But ultimately, it is up to us to conduct these reviews in a way that can be an example for others to follow. We need to hold each other to a higher standard and this is one way to accomplish that.