



Joel M. Press, MD
Rehabilitation Institute of Chicago
Chicago, IL

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FROM THE DESK OF THE PRESIDENT

Dueling Outcomes

Nothing ruins a good outcome like further follow-up.

Statistician's folklore

In this era of evidenced-based medicine, quality care guidelines and pay-for-performance measures, greater scrutiny is placed on the way medicine is practiced. Clinical experience alone is insufficient. With more data available electronically, particularly scientific studies and discoveries, more health care consumers (and even more so, health care payers) are demanding good outcomes for each and every intervention provided by health care providers. But what is a “good” outcome?

To the insurance company, a good outcome has several different meanings. Did the patient improve with the prescribed treatment and is he pleased with the contracted physician? Was the cost of care for that particular diagnosis within the insurer's financial framework, ie, are they still making a profit? Is the patient satisfied with the insurance company's policies and procedures? The answers to these questions may vary. Which outcome is most important to them?

Medicare and Medicaid, the largest payers of health care in this country, are facing these same questions every day. The US economy cannot afford these programs indefinitely with steadily increasing health care costs. Which outcomes will become their priority?

A hospital administrator may have different definitions of a good outcome. Did the patient receive appropriate care for her problem? Did the patient suffer any complications related to her care? Did the hospital receive reimbursement for the patient admission and realize a profit?

Will the patient refer others to that hospital? Many of these outcomes relate to the perception of the patient; others relate to financial concerns.

The treating physician will also have different outcomes to consider. Is the patient better? Was he satisfied with the medical care? Did he pay the bill? Did he speak favorably about the physician to others? Understanding if the patient is healthier is just not enough.

I recently spoke to a patient about an issue unrelated to a previous condition that I had managed. I had seen her two years previously for a herniated disc and sciatica. When I first saw her she was in severe pain and not able to work. After an epidural steroid injection she improved greatly. She experienced a good pain outcome (no residual pain) and a good functional outcome (successful return to work). When I last saw her, it was an eight-week follow-up visit. She was still doing well and we were both pleased. However, when I talked to her recently, she relayed to me that she had done well for 1½ years, then had a severe flare up, ultimately undergoing a microdiscectomy and was now feeling “great.”

My impression of her outcome from my treatment was very favorable. However, to the surgeon who performed the discectomy, her outcome with nonoperative care was not as favorable. Maybe the next physician who sees her in the future will not think highly of either of our outcomes. If I had not serendipitously called her I would not have known her real outcome (at least up until now).

The point is that patients' disease processes, pain complaints, and overall physiology and pathology of their disease are a moving target. They are a continuum of signs and symptoms that any one of us may only see at one point in time, or if we are fortunate enough to have our patients return to our practice, many points in time. Symptoms may wax and wane. They may reach critical points when we are treating them, or they may not. We have to keep a perspective of the entire continuum of the natural history of a disease, and what effect specific treatments have on that natural history when we look at our own outcomes or when we interpret the literature. The specific point in time when we see a patient in his continuum of signs, symptoms and disease process may be the critical factor in recommending different treatment options with potentially very different outcomes.

Finally, and probably more important than all the rhetoric about what constitutes a good outcome to all of the stakeholders described above: what was the patient's experience? Is that not our

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top priority in medicine? What dictates a good outcome to our patients? To make that determination, we need to first understand what our patients' concerns, priorities and goals are for seeing a physician or seeking medical care. Obviously, if a patient is emergently admitted to a hospital with an unstable spine fracture, his primary outcome is avoidance of paralysis. When she shows up in my office with generalized axial low back pain, it may be difficult to know the desired outcome. Does she want pain relief? Does she want to know that she does not have cancer or that she can still golf and not cause irreparable damage to her back? What about the future? Will she

need surgery? Although we like to think that our job is as "simple" as decreasing pain, the outcome desired by patients is rarely that obvious.

What patients consider a good outcome and what we consider a good outcome are, at times, dueling outcomes. We may want to fix their anatomic problem when they want assurances that they can still play with their grandchildren without causing "damage." We need to understand each patient's idea of a good outcome in order to truly measure the desired end points and change potentially dueling outcomes into shared successes.