So, You Want to See How Your Patients Are Really Doing?

It is not uncommon for a surgeon to be asked, by a patient who is deciding whether to undergo a particular surgical procedure—say, a bunionectomy or hammertoe repair—a question that goes something like this: “How many of these have you done?” Or, the savvier patient may inquire: “How many of these have you done in the past year?” And the follow-up question may go like this: “What are your results?” Providing a reasonable answer to the first question is not difficult, since the CPT code can readily be selected for retrieval from your billing software, and you can even specify the time period for which the software algorithm harvests the procedure code or codes. I think that it would be an interesting exercise for surgeons to estimate the answer to the “How many have you done?” question, and then check their electronic records or surgical case log and compare the two answers. I suspect they would find either overestimations or underestimations of the actual results.

In regard to answering your patient’s second question, the one about your surgical outcomes, an accurate answer is a bit more difficult to provide. Usually the answer is derived from an honest effort to recall one’s surgical outcomes, but recall bias is likely to influence the answer. Of course, if we are performing a particular procedure regularly, it is likely that the outcomes we are achieving are beneficial to our patients most of the time.

But with just a little preparation, we can be in a position to answer that patient’s question about outcomes very accurately. To do this, the following measures can be helpful. First, prospectively collect selected outcomes information on every patient in an organized fashion. (Including all of your patients prospectively minimizes selection bias in your patient population.) Second, be selective in the information that you collect to measure your results. One of the most basic, and easiest to obtain, measurements is the subjective 10 cm visual analog scale (VAS) measurement of an individual’s pain experience. If this scale is included in your initial patient intake information, then you have it for every patient prior to the start of any form of intervention. At any time after treatment, the VAS can be readministered, and a reasonable comparison of the effect that your intervention has had on the patient’s subjective evaluation of pain can be determined. Finally, in an effort to determine just how much a patient’s foot pathology influences their quality of life (QOL), prospective administration of a health measurement instrument that has been shown to be reliable (hence, likely to provide a valid measurement of one’s subjective foot-related quality of life) could also be obtained when the patient completes the initial intake paperwork. The QOL health measurement instrument should be short and easy for the patient to complete. Potentially useful questionnaires for this task include the Bristol Foot Score (15 items) and the revised Foot Function Index (34 items), although there are other acceptable QOL questionnaires. The key to making these useful for the purposes of routine data collection is to keep the survey brief and understandable, so that patients are likely to answer all questions completely. Have your patients repeat the VAS, or the foot-related QOL questionnaire, at, say 3 and 12 months after the intervention, and you will be able to provide a very accurate answer for your inquisitive and well-prepared patient.

Of course, there are other methods that can be used to more scientifically ascertain patient outcomes. However, the suggestions that I have described above can be readily implemented and will, in a relatively short period of time, enable surgeons to more accurately know how their patients are doing. Suggested articles for interested readers include:


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