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Spinal surgery: Who is in charge anyway?

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Abstract

Background: More and more, no one seems to be in charge of taking care of patients with spinal disease both before and after spine surgery. Yet, as spine surgeons, we should not have to direct basic medical clearance prior to surgery, or direct basic medical postoperative care.

Methods: As we as spine surgeons did not complete medical residencies, why are we now being asked to take care of all postoperative issues in our patients undergoing spine surgery. As "captains of the ship," we are increasingly managing hypertension, diabetes, deep venous thrombosis/pulmonary embolism, and other basic medical issues.

Results: Although our medical colleagues perform the preoperative clearance, too frequently they are not involved in the patients' follow-up treatment. Often, our medical colleagues are nowhere to be found after surgery for any of the postoperative problems; therefore, "tag" we are it. Nevertheless, this should not be the case.

Conclusions: So I ask again, who's in charge? Are we as spine surgeons now supposed to become the patients' primary care physicians, their pulmonologists, cardiologists, pain management specialists, much less their psychiatrists. Unfortunately, if we don't do this, no one else appears to be willing to step.

Key Words: Medical clearance, no one in charge, postoperative care, preoperative care, spinal surgery

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EDITORIAL

More and more, no one seems to be in charge of taking care of patients with spinal disease both before and after spine surgery. Whether one is a neurosurgeon or orthopedic spine surgeon, we should not have to direct basic medical clearance prior to surgery, or take over all basic medical postoperative care. Nevertheless, with reimbursements being restructured, and our medical colleagues having to see an enormous number of patients to make ends meet in their offices, we, the spinal surgeons, are being asked to medically manage patients both before, and more critically, after surgery.

When did we as spine surgeons complete our medical residencies? If we did not, and most of us went directly into general surgery internships followed by neurosurgical or orthopedic residencies, why are we now being asked to take care of all postoperative issues in our patients undergoing spine surgery? As "captains of the ship," we are increasingly encumbered in managing hypertension, diabetes, deep venous thrombosis/pulmonary embolism, and other basic medical issues that should be treated by patients' medical consultants.

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Increasingly, our medical colleagues perform the preoperative clearance, but too often they are not involved in the patients' follow-up treatment. Instead, patients often find it easier to contact their surgeons than their primary care MDs or other medical specialists, including their pain specialists, who were only too happy to perform multiple unnecessary epidural steroid injections prior to surgery. In short, our medical colleagues appear nowhere to be found once there is limited to no further reimbursement for basic patient follow-up care. We, therefore, have to answer the postoperative calls pertaining rarely to the surgery itself, but more typically to medical issues. Why? because "tag" we are it. But that shouldn't be; the on-going treating medical physicians should be responsible for continuing postoperative care just as they had rendered preoperative medical clearance.

So I ask again, who's in charge? Are we as spine surgeons now supposed to become the patients' primary care physicians, their pulmonologists, cardiologists, pain management specialists, much less their psychiatrists. Unfortunately, if we don't do this, no one else appears to be willing to step up to the plate.

Commentaries

One answer to the problem of medical management of hospitalized surgical patients is the hospitalist. Is that not a part of their job?

Howard Morgan

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As medical care has become more complex, it is necessary to have a team of physicians to care for many of our patients. As surgeons, we are in charge in the operating room; but patient care is in cooperation with our anesthesiologists. In the pre- and post-operative care, it is common to utilize other specialists to assure complete and competent care. In the past and currently, insurance companies approved the need for additional consultation in complex cases. A drug addicted, brittle diabetic, with serious heart disease, etc., or comparably complex patients can have other issues beyond our expertise and additional medical consultations are appropriate. I have always welcomed the additional assistance, especially when the call in the middle of the night comes concerning a bad blood glucose determination. I have had no problem working with my colleagues and encourage such behavior. After years of living near our nation's capital and witnessing a disgruntled government, I am not interested in a command struggle. I believe in mature cooperation to render the best care.

Tom Ducker

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This editorial provides a brief glimpse of the future of neurosurgery. The view is distressing, even chilling. The practice of spine surgery is under intense scrutiny, much of which is unfavorable, if not hostile. From within its own ranks come unchallenged reports that much of spine surgery, especially for degenerative diseases, is unnecessarily performed, with increasing complications and costs, a finding echoed by others within the medical profession. Lucrative relationships between surgeons, including published investigators and the spine instrumentation industry, raise sobering questions of conflicts of interest. Public commentators have widely distributed these concerns, along with their own condemnations. Public officials state without equivocation that costly and unnecessary surgery is being performed. Reimbursement rates, tied to performance, are falling, and there are those pledged to see this continues. And now Dr. Epstein describes a collapse of professional collegiality over medical management of patients undergoing spine surgery, with issues of reimbursement at its center. Arguably, neurosurgery survived as a strong and influential medical specialty during the last two decades of the 20th century because of the economics of spine surgery. Now, with the majority of physicians initially trained as neurosurgeons devoting their practices entirely to spine surgery, the shadow of a tragic irony looms: could the specialty of neurosurgery collapse and lose its individuality because of the economics of spine surgery? If there was ever a time for leadership, it is now. Who is in charge, anyway?

Clark Watts

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My experience with this issue is somewhat different. At the community hospital where I practice (albeit in a limited role), the primary care physicians are only too happy to take these patients on their service and care for all of their postoperative medical issues. They obviously defer to us on problems with wounds, physical therapy, and postoperative follow-up. If elective patients are admitted by the surgeon, we have had no problem having them seen by appropriate consultants. I do the bulk of my work at the university hospital, where patients with multiple complex comorbidities are routinely on the medical service. Elective patients are seen in a preoperative assessment testing clinic, and the routine postoperative care is handled by the surgeon – admittedly with a team of residents and/or dedicated nurse practitioners. All patients requiring neurosurgical Intensive Care Unit (ICU) care are either on the ICU service or co-managed with a dedicated neurointensivist. Again, consultation has generally not been a problem. I would be uncomfortable trying to manage some of these patients on my own, and I'm at a bit of loss why it is so hard for patients in other institutions and settings to have appropriate medical care. The advent of hospitalists has solved a lot of these problems where I practice.

Paul Arnold
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I am in full agreement with Paul (Arnold). That is the same situation we have at our university.

Bob McGuire
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I tend to agree. Though retired from neurosurgical practice (NS) now, I was in a private, nonacademic neurosurgery practice for over 40 years. I was not just trained to be a human being first, a physician second, and a neurosurgeon third. I was not trained to be a technician, a person good with technical skills ready to fix a problem whenever requested.

With such a mindset, I took total responsibility for my patients' well-being from start to finish within the scope of my competency. In most cases, this was not a problem. For those patients with medical issues beyond my competence, I would happily request consultations and participatory follow-up care. This also was never a problem. My colleagues always were happy to support me and my patients, as I was happy to support them and their patients when the occasion arose. We called it collegiality. However, regardless of the circumstances, I always considered myself to be primarily responsible for my patients' safety and well-being. It was my duty; it was my pleasure.

Phil Lippe
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I agree with Dr. Lippe very strongly!!! Despite all the problems in medicine, the physician that the patient has the primary relationship with has to stay involved and in charge. It is nice to delegate some questions to consultants but we are all trained in all aspects of medicine and so it remains important to stay in control of the patient's management.

Mark M. Stecker
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I have not responded because I, like Phil Lippe, am retired. As it turns out, the last surgical procedure I actually carried out was in 1998. I was, however, privy to such procedures intimately thereafter because so many of the people I treated as a "pain doc" had either been recently operated on or were about to undergo surgery. As a consequence, I and my entire pain center staff became intimately involved with our patients who were undergoing such surgery in the acute instance. We regularly followed such patients throughout the course of surgery and follow-up, which gave the psychologists, especially a perspective they had not seen before, and we were able to translate the "comprehensive, multidisciplinary" concept to the acute situation, which was most valuable and, as it turned out, most appreciated by the primary surgeon. This concept, I think, aborted the argument of who was in charge because any unusual situation was immediately noted and responded to through the efforts of the "team," which included the residents and attending of the surgical staff as well, who were discussing the case among themselves on an ongoing basis. Involvement of "primary" and other "specialty" care was just a routine matter. Our relationship and reputation with the insurance industry may well have obviated any disagreement from them and reimbursement never came up as an issue, once our system was in full function.

When Jim Ausman took over as head of the Neurosurgery Department, he brought his entire team to a staffing session of the pain treatment center to see how it worked and

injected the concept into his department at the University of Illinois, where I continued to work as a consultant.

As you know, many insurance companies regularly employ nurses to follow patients undergoing complicated surgical procedures, and when "neurosurgery" is mentioned that is usually interpreted as a "complicated" procedure, even when it involves the spine in relatively routine matters. Such nurses are well informed about the procedures they attend and also know the reputation of the team involved, which often is another positive point and impacts treatment function of the team.

But I have carried on too much. Good fortune on your effort and continue on as always,

Ron Pawl

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Thanks for inviting me to participate in this discussion. I appreciate the comments by the previous authors, and this issue is certainly timely as just yesterday I had a conversation with our hospital administration about this very issue; "optimizing peri-operative care." As Nancy comments, based on numerous factors and pressures, the "ideal" perioperative care and the actual perioperative care have diverged as primary medical docs rarely round on inpatient wards. To this end, what I believe to be the ideal model is a new field of medicine called "perioperative care." This mixes primary care, critical care, and anesthesia. Each surgical patient would visit with the perioperative specialist pre-op and then the perioperative specialist would see all of the post-op patients in the postanesthesia care unit and subsequently on rounds until the patient is discharged. This physician would be responsible for all medical needs for the patient for the first 3 months following surgery, at which point the patient's primary care physician would take over. The pushback I have received thus far is based on the cost of funding a full-time equivalent (FTE) for this position in a health-care environment that is looking to reduce rather than add costs to the equation. The only way I believe we will be able to justify this will be to create an equation in which the cost of preventable medical complications outweighs the cost of the physician FTE.

Until the day comes when this dream could be realized, the solution at our hospital has been to employ a team of Physician Assistants (PAs) who cover the medical needs for our hospital 24/7 with direct communication to us. Thankfully, we have an excellent critical care staff who are very accessible for medical issues that go beyond the scope of the PAs.

Justin Tortolani

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I will not reiterate my previous comments, but I strongly avow them. Dr. Justin's comments are interesting and valid. Perioperative care is a specific discipline in medicine. The specialty of anesthesiology includes this within their scope of practice. Anesthesiologists assume responsibility and care for patients before, during, and after surgery. However, their scope of care encompasses events related to surgery only. It does not include preexisting conditions *per se*. Nor does it exclude requesting a consultation from another specialty as may be indicated by the presence of a specific problem.

I believe the different attitudes about perioperative care in large measure are dictated by the size of the hospital, its academic venue, and perhaps its geographical location. My hospital is a large community hospital in California with eight neurosurgeons on the staff. All fiercely defend their right to take medical care of their patients on the floor and in the ICU. They also freely resort to consultations from other specialty fields and work hand in hand with intensivists. All this seems to work smoothly with few if any disagreements. In the final analysis, it results in achieving the safety and well-being for our patients.

Phil Lippe

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