5/17/2011

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Dear Mr. Martin,

I wish to comment on the recent reporting of PHC4 (2008-2009) CABG Surgery Data to be released May 19, 2011. Various hospitals have submitted data on my behalf to PHCCC for 10 years, and as one can imagine my dismay of seeing for the first time ever in any category a higher than expected rate and in specific a higher than expected mortality after CABG. I was just made aware of it today and certainly do not significantly dispute the data, just the methodology I however strongly feel the need to make several comments.

The first comment I wish to make is the "overlapping" two-year reporting interval. "One" extra mortality in 2009 makes overall numbers for 2008-2009 high and then even if 2010 is a normal year the 2009 data will make 2009-2010 data look high again. It would seem most efficacious to report data 2007-2008 then 2009-2010 and so on and not 2007-2008 then 2008-2009. This would avoid the issue of a surgeon being told he has higher than expected for two reporting periods in a row, but as a result of a single year all other things being equal. Is also less than useful to be reporting data from 1/1/2008, which is almost 3 1/2 years ago and may or not be anywhere remotely reflective of current 2011 data. It would seem that reporting 2010 data in the spring of 2011 would be most appropriate.

While the data is somewhat risk stratified it is for the most part administrative code based data and is nowhere near as robust as the Society of Thoracic Surgeons DataBase in which my results are as expected for each year for the last five years.

There are certainly issues with this PHC4 database suggesting an increased mortality when a much more robust database does not.. This does call into the question as to why this much lower quality data base is even being used in the is state anymore when the STS data base has existed for over 2 decades and all surgeons would agree is much more reflective of true mortality rates.

The above comments not withstanding, my thoughts certainly echo the other letters that you have been sent this year, I certainly don't enjoy seeing my name on this list (although seeing some other nationally prominent and world leaders in various fields on this list this year takes some of the sting out of it) and I would like to

dismiss it, as I am quite happy with my STS database analysis, but I can't obviously do that.

Since providing good care to patients is what it is all about. I have reviewed my personal data for 2008-2009 to see if anything can be gleaned from this report and I have as of today found that that your data seems to be missing several cases specifically with some in the CABG (all of which had no mortality) and will work to identify those cases to PHC4 if that is even possible or allowed at this point in time.

In terms of specifics in the category that was rated higher than expected mortality (CABG only). I feel the need to point out that I experienced only 2 mortalities over the entire 2-year period (2008-2009), which unfortunately with a small overall N seem more prominent. My over all caseload is relatively top heavy with low EF, redo Valve/CABG, aortic work and other cases not captured by this database as well as general thoracic and vascular work. However in this model with a relatively low N, risk stratification is unable to over come pure percentages as others have pointed out in you other letters on the web site.

Since PHC4 just listed "higher than expected mortality for CABG" with no further numbers or how much higher than expected I can only reference the actual mortalities. My over all mortality in ALL categories for all heart surgery including the cases that your database does not even capture is 3 patients over the 2008-2009 2 year reporting period.

> *The FIRST was a patient that passed away unfortunately, acutely and unexpectedly after a "routine" off pump CABG x2 from a bradycardic episode in the ICU possibly related to an secretion obstructed endotracheal tube with who was resuscitated and taken back to OR with open grafts and no etiology found and eventually she passed away.*
>
> *The SECOND patient was very sick with unstable angina, steroid dependent COPD, mod renal dysfunction, active 3 pack a day smoker, and severe peripheral vascular disease with lower extremity rest pain and a history of multiple prior pneumonia's that underwent urgent and uneventful CABG x5. Several days post-op the patient thrombosed both of lower extremities and eventually required bilateral above knee leg amputation and then developed viral herpes pneumonia and passed away after a lengthy stay in the ICU.*
>
> *The THIRD and only other patient mortality that was not included in any of your categories and not part of the CABG only analysis passed away after a complex aortic case secondary to retroperitoneal hemorrhage while on cardiopulmonary bypass.*

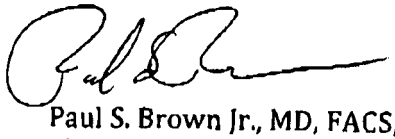
All of these 3 cases (only 2 were CABG only) were presented at surgical morbidity and mortality conference and it was felt nothing differently could have been done.

From looking at the current list I realize that is may seem self-serving to try to explain a category, but I think that it is required when this data is just presented in a very basic form as it is on the current PHC4 publication. I know most cardiac surgeons nervously open it each year and hope that, but for the grace of God they did not have a handful of clustered cases that would put them on the list for that reporting period. And although these two cases may put me on the list for the higher than expected mortality period for 2008-2009 (and I am still uncertain as to why even rudimentary risk stratification did not straighten that out) and may very well put me on the list for the period period 2009-2010 as well, I don't feel that they are out of the ordinary or reflective of any adverse trend in my own series of patient's or of the hospital that I practice at, nor could I honestly say that I would have or could have done anything differently in those patients.

Seeing my name here because of agreeing to operate on ONE very sick patient with unstable angina and high surgical risk, for which there was no alternative and who basically died of non cardiac causes, does give me pause for when agreeing to take on other not necessarily surgically difficult, but high risk patients in a smaller volume institution that has a higher patient acuity that is not as accurately accounted for in the PHC4 database as the STS database, when I know the care is the same as in a larger N institution.

I hope that my comments may be useful to the PHC4 in term of data analysis and also serve to specifically address my specific data report. I appreciate all the work that PHC4 does and it is certainly a massive undertaking to collecting all of this data, but it does seem redundant and less robust and therefore less reflective of actual care than the STS database.

Sincerely,



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