

References

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examine “The Rule of “W” in Urology,” a rule-concerning temporal association of postoperative complications. The authors are to be commended for challenging surgical dictum and dogma through proper study rigor by comparing 30-day morbidity in 60,000 urology patients with 450,000 general surgery patients. A thoughtful description of the complications, not only from a rate perspective, but also from a time perspective is given. The data provide insight on proper differential diagnosis in evaluation of postoperative patient issues during and beyond the hospital encounter. Additionally, the data also show “a one-size-fits-all” approach to postsurgical patients is inappropriate as the timing and frequency of complications differed between the 2 groups. This manuscript is meaningful for, not only attending academic physicians and private practitioners, but also for residents or other providers seeing these patients in the postoperative setting.

Furthermore, complications are profoundly expensive with estimates of \$6,000,000 annually for academic institutions.³ Moreover, complications in Partial Nephrectomy, a NSQIP-included procedure, were found to increase cost by \$3700 per case with certain morbidities increasing cost by over \$30,000.⁴ Complications decrease value from both the cost and outcomes perspectives. As we continue to move toward value-based reimbursement, the effect of complications on value will only become more apparent. Proper and timely identification of complications have the potential to mitigate associated decrease in value, and likely represents an appropriate quality improvement focus.

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EDITORIAL COMMENT



The National Surgery Quality Improvement Program (NSQIP), which began in the Veterans Affairs’ hospital in 1991, was “the first national, validated, outcome-based, risk-adjusted, and peer-controlled” database for use in measuring and enhancing surgical quality.¹ The NSQIP was subsequently adopted by the private sector given the potential for the availability of widespread outcomes data to be used for quality improvement.² In this thoughtful manuscript, Dr. Rocco et al use the NSQIP database to

AUTHOR REPLY

The authors wholeheartedly agree with the comments from Dr. Harris. Several national scale outcomes-based programs, NSQIP being one among them, are in place to allow us to perform more robust analysis into the risk factors for morbidity in our patients. Use of these statistically validated,



multi-institutional models will help to advance urology and improve the overall quality of the care we provide.

Additionally, the Accreditation Council for Graduate Medical Education has identified health care quality as one of its focus areas within the clinical learning environment (CLE).¹ Within this focus area (and one of the overarching goals of our urology residency programs) is the aim of advancing residents from the learning stage of awareness, to knowledge, to demonstrated competency in the area of quality improvement. Data systems such as NSQIP can be leveraged to teach residents how to utilize data directly from their patients to improve the quality of the health care they provide. In this study, our group was also able to use this information to challenge traditional surgical educational

paradigms and, hopefully, improve the quality of our resident and medical student education as well.

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