Editorial

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SURGICAL ENDOSCOPY
and Other Interventional Techniques

Do we need consensus conferences?

In order to make appropriate medical decisions—an everyday task—medical doctors rely on several sources of information. Past medical education is one source, but who would challenge that what we learned yesterday is often no longer valid today? Experience, which surgeons are well known to champion dearly, is another source, but the subjective, biased, and invalidated character of this source, and the imperfections of transmission (from "master" or "mentor" to "disciple"), leave much to be desired.

Ideally, decision-making, evaluation, and applicability of new surgical procedures, diagnostic tests, or therapeutic policies, as well as formation given to outpatients, should be based on the best currently available evidence. This evidence is usually harvested from unbiased sources, most often randomized clinical trials and, whenever possible, *high quality* meta-analyses. Still another source of information is "consensus development conferences," their variations, and their natural offspin—guideline developments—which often incorporate "appropriateness" criteria.

Informal consensus development, the oldest and most common approach, is now practically abandoned because of faulty methodology. Informal consensus development has been replaced by formal consensus development, which strives to overcome shortcomings by a systematic approach to assess expert opinion, and then by "consensual" agreement, producing recommendations. Evidence-based guideline development, recently the topic of a new tool, the AGREE statement, links recommendations directly to scientific evidence of effectiveness, with rules of evidence taking precedent over expert opinion. Explicit guideline development clarifies the rationale by specifying the potential benefits, harm ("appropriateness"), and costs of available interventions (cost-effectiveness and efficiency). Explicit guideline development includes a complete array of possible outcomes and includes the desirability of outcomes based on patient preferences (quality assurance).

Fellow surgeons of 2002, where do we stand today?

The main goal of consensus conferences is to define levels of agreement and disagreement on controversial topics. In view of their conduct, ultimate diffusion, and use and utility, however nothing could be less regularly attained with rigor. One possible reason is that national needs and practice differ from one country to another. An example might be antithrombosis prophylaxis. Second, they are labor-intensive and time-consuming; one conference usually takes between 12 and 15 months to organize and runs for at least 2 1/2 days. Third, the manner in which consensus conferences are conducted can strongly affect the value and validity of the final product as biases can be introduced at variable levels. These biases may include: (1) choice of questions, speakers, and panelists, as well as the leaders of the working parties; (2) examination and eventual synthesis process of the relevant literature; (3) running of the conference (organization of the panels, the choice of leaders, the environment and timing, just to name a few variables).

Moreover, depending on the criteria set forth for making decisions and the way disagreements are handled by the organizers, and also the manner in which voting or polling of panel members is achieved, consensus statements often represent the "middle of the road," or the "lowest common denominator" of opinion, and the statements can be far from the cutting edge. Occasionally, consensus statements leave major problems frustratingly unresolved. It must therefore be the goal of every consensus to end up with final statements that are as specific as possible. That is, exact information is needed as to what something means, what should be done, and what data are required. If no consensus is possible on certain points, the reasons must be stated.

Last, needs differ according to their ultimate use. Consensus conferences can be used differently by medical professional societies to establish recommendations and guidelines. Conferences can also be used by private and third-party payers to define the diseases and operations that require coverage and to set reimbursement policies. They also can be used by surgeons and their societies to assess state-of-the-art medical and surgical procedures, to evaluate new and unproven technologies, to define standards in medical practice, to bridge gaps, and to resolve disparities among research findings and clinical reality.

"Appropriateness" has been described as the next frontier in the development of health care. The growing interest in appropriateness has been fueled by the dramatic growth in expensive medical technologies and services that may reduce surgeons' ability to give everybody access to effective care. Moreover, the sheer volume and complexity of available services has made it virtually impossible for clinicians to practice good

medicine without ongoing decision support. This has led in turn to an explosion in the development of clinical guidelines. However, few of these guidelines are user-friendly or evidence-based, and it is generally accepted that 20–60% of patients either receive inappropriate care or are not offered appropriate care.

Appropriateness, a complex issue with various dimensions, relates to judgment regarding care at different decision levels (such as health care delivery, health care policy, and research and development), which enlaces clinical, public health, economic, social, ethical, and legal considerations. It is therefore important to consider who makes the judgment, what evidence is being considered, and which process of consultation is being followed. The key issues to be addressed include: is care effective based on valid evidence (''evidenced based'' medicine), and is care efficient (cost-effective) and consistent with the ethical principles and preferences of the relevant individual, community, or society? The priorities given to each of these dimensions vary in different populations, countries and cultures.

With these needs in mind, the Executive Committee of the European Association for Endoscopic Surgery (E.A.E.S.) decided to hold consensus development conferences that were conceived, modified, and developed by Troidl and Neugebauer from Cologne, Germany. The premise of these conference was to fulfill these demands. Conducted and published in *Surgical Endoscopy* by E.A.E.S since its inception in the Madrid E.A.E.S. meeting in 1994. As of today, six CDCs have been performed in conjunction with the annual meetings of the E.A.E.S. In March, 2002, in New York, the Society of Gastro-Enterology Surgeons (SAGES) held its first ''appropriateness'' conference on laparoscopic hernia repair, appendectomy, GERD, and colonic surgery. The results of the consensus will soon be published in *Surgical Endoscopy*.

What about the impact?

The facts are disappointing, then, when we look at the impact consensus conferences and their variations, as well as the consequent recommendations of the guidelines, has on medical decisions. Several surveys, both in North America and Europe, have shown that the recommendations are not heeded, or if they are heeded, many years go past before they are, and some recommendations may no longer be of interest. Is this because the embedded biases in surgeons' minds are difficult to recognize and shed? Is this because the recommendations are so vague (''lowest common denominator'') that the conclusions no longer correspond to doctors' and patients' expectations? Is this because no one has yet convinced the surgical community that recommendations originating from these instances represent something worth following? Or, further, is this because individual surgeons do not like or want to follow rules that have been drawn up by others, however famous or politically recognized (there is no police enforcement here!)?

As doctors, and surgeons, our mission is to treat patients to the best of our knowledge and expertise. The exponential knowledge eruption and the nearly daily skill-related technology advances in minimal invasive surgery make it more than ever mandatory that we, surgeons and doctors, humbly examine, analyze, and objectively audit our own practices. Every surgeon must ask him or herself, ''how far away from the standard of care am I?'' Why? We have to recognize and discard our acquired biases, and base our diagnostic procedures and surgical therapy on ''hard'' evidence. We then must evaluate our results to learn whether we have improved our outcomes. We must continually strive to learn from updated, acknowledged sources of evidence, and we must realize that our ''true'' art is being able to harmonize knowledge with skills in bringing effective and efficient solutions to disease, with minimal harm and proven benefits to our patients. The solutions must be adapted to patients' preferences, needs, and consent. Consensus conferences are one of many ways to move in this direction, but only if the rules in their conduct, and in the diffusion of results, are respected. Last, but far from least, we as members of the surgical community direly need to control the quality of our sources of information, to control the consensus conferences, and above all to audit how the individual surgeon complies to the recommendations.

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