Publishing consultant outcomes data: room for improvement

In June 2013, NHS England began the staged publication of mortality rates for individual hospital consultants in ten specialties where national registries existed. They were: adult cardiac, bariatric, head and neck cancer, colorectal, urological, cardiology, vascular, orthopaedic, thyroid and endocrine, and lung. The work was led by the Health Quality Improvement Programme for NHS England and is based on national clinical audit data. The aim is to give patients more information about their treatment, helping the NHS drive up and maintain the quality of care. The data in 2014 include around 4000 consultants, cover a range of procedures from the ten defined surgical specialities and the information is available on the website NHS Choices. It will show the number of times a consultant has carried out a procedure, mortality rates and whether clinical outcomes for each consultant are within expected limits. The specialist societies that have produced the data will also include additional indicators where appropriate to their specialty.

In an era of openness, transparency and public accountability, few would disagree that there is no reason why surgeons' outcomes should not be available. However, the challenge for the surgical community is to ensure that the information is accurate and meaningful. Further, publication of crude mortality rates alone can be misleading and may detract from other important issues in patient care. There are a number of reasons for this which are outlined below:

Individualized data

These can be misleading and cause unnecessary concern and reputational damage. Reasons for this include low volume, difficulties with case mix and risk adjustment, the accuracy of data collection and institutional factors. Few surgeons perform large numbers of a specific operation in a short time interval. As such a small denominator means that identifying outlying performance is difficult or, at the very least, necessitates a prolonged period of observation. If for example a colorectal surgeon does 20 resections a year it has been estimated that a minimum of 5 years' data are required to make statistical analysis meaningful.

Risk-averse behaviour

There is some evidence to show that one consequence of publishing individual surgeons' data is to encourage 'risk-averse behaviour'. This is not in patients' best interests. The drivers for risk-averse behaviour are self-protection or prestige and possibly private practice that comes with being well placed in league tables. Risk-averse behaviour leads to 'gaming' of results whereby surgeons reclassify patients, for example, from elective to emergency.

However, risk-averse behaviour can be a catalyst for good practice. If a surgeon considers that the institution in which he or she works cannot provide the resources deemed appropriate for the care of a particular patient, then this is an incentive to refer to an institution that does have all necessary facilities.

Unit *vs* individual data

There needs to be wider debate about whether data are published at surgeon or unit level. Much of modern surgical practice relies upon close cooperation between teams of clinicians, nurses and other health-care professionals. It also relies upon complex infrastructural, managerial and administrative arrangements within provider units. It can be argued that in many instances negative outcomes result from failures of process and systems, and not of individuals. In particular, there is increasing recognition that 'failure to rescue' after a complication occurs is at least as important as individual surgeons' performance. Centres that have the same incidence of complications after an operation may have significantly different mortalities reflecting team consistency, patient-to-nurse ratios and a host of other possible variants, all of which may contribute to failure to rescue.

Perhaps the biggest flaw in the justification of publication of surgeons' mortality rates relates to the simple fact that these days few deaths can be attributed to surgical error alone. As such, publication of surgeon-specific mortality data merely serves to distract attention away from institutional failings. The statistical finding that a surgeon or surgical unit's outcomes diverge from those expected should not be an end point in itself; it should be the stimulus to the start of a process to explain this divergence. This should not preclude appropriate and timely action to protect patient safety. The publication of outcome data before the above process is complete has no benefit but some significant disadvantages:

- It misinforms patients, as without the steps outlined above it is not known whether or not the statistical finding is of clinical significance
- It may cause unnecessary anxiety to patients who have been, or are about to be, treated by a surgeon identified as an outlier
- It does not provide patients and the public with reassurance that any clinical concerns have been acted upon.

In future, data should include duration of hospital stay, returns to theatre and other defined beneficial outcomes depending upon surgical procedure.

Informing patient choice?

Another argument often advanced to justify publication of outcome data is patient choice. Patient choice should be based upon clear and understandable information about the quality, safety and patient experience in a provider unit. Assuming that each provider unit has an obligation to ensure that any individual involved in patient care is practising safely, publication of individual data is unlikely to be of benefit or used by patients or their referrers to

exercise choice. Put simply, provider units should not be allowing surgeons to practise unless they can demonstrate that they are doing so safely, and there are now elaborate institutional processes in place to try to ensure this. Further, choice is often impossible in reality; those requiring emergency or urgent surgery do not have such a choice and with the increasing use of pooling of waiting lists to meet waiting time targets, an elective patient may 'choose' a surgeon but then see one surgeon in the clinic and have the operation performed by another. For these patients it is important to know that the unit is safe, or alternatively to be allowed to stay with the surgeon of their choice.

Conclusions

All four surgical royal colleges and the ten General Medical Council recognized surgical speciality associations agree that surgical outcome data should be published and not to do so implies that surgeons have something to hide. However, publication of individual surgeons' mortality data alone is insufficient and possibly misleading. The next few years will see increasing sophistication in what is made public and there is likely to be greater emphasis on unit and trust outcomes. This information, if accurately collated and clearly presented, would be a valuable service to the public. BJHM

KEY POINTS

- The Federation of Surgical Speciality Associations UK and Ireland, which represents surgeons of all specialities, approves in principle the reporting of surgeon outcome data.
- There are significant drawbacks to reporting mortality data in isolation.
- There are significant drawbacks to reporting individual consultant data as opposed to unit or trust outcomes.

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This editorial is based on a position statement written and agreed by all ten specialty associations and listed on their web site (www.fssa.org.uk/).