

Ethical and Legal Issues in Performance Monitoring and Disclosure

Justin Oakley

Centre for Human Bioethics
Monash University

justin.oakley@arts.monash.edu.au

Background

- Performance monitoring raises many issues, but collecting performance information for *public* reporting raises further ethical issues.
- Surgeon-specific performance data ('report cards') have been publicly available in several US states (eg New York, Pennsylvania) since the early 1990s.
- Following the Bristol inquiry, the UK SCTS published some surgeon performance information in September 2004. This information indicates, for each cardiac surgeon, whether s/he is within an acceptable level of performance (as measured by in-hospital mortality). A three-point scale is used.
- The UK Healthcare Commission is publishing risk-adjusted performance data on individual cardiac surgeons on their website this month (April 2006). However, only one-third of cardiac surgeons will be involved (at least initially).

Three ethical arguments for publishing surgeon performance data

1. Respect for/promotion of autonomous decision-making by patients
2. The importance of professional accountability to the community
3. Improving the overall quality of surgical care

1. Respect for/promotion of autonomous decision-making by patients

Informed consent and report cards (Clarke & Oakley 2004):

- ◆ Disclosure of reasonably foreseeable risks of a procedure is necessary for informed consent.
- ◆ A given patient in a sub-group at a higher risk than the general population should be informed of the risks to that sub-group, if known.
- ◆ Just as specific information about the patient can be relevant to the probability of a given outcome materialising, so too can specific information about the surgeon (eg. about their surgical performance).
- ◆ If such information has been collected, it should be made available to patients who see it as relevant.

2. The importance of professional accountability to the community

The community has a right to know surgeon-specific performance data, to determine whether surgeons are providing services of the requisite quality, under which society agrees to grant them a monopoly of expertise in the first place.

3. Improving the overall quality of surgical care

Report cards lead to overall improvements in the quality of surgical care in the long term (New York State, Chassin).

- ◆ Some surgeons with below-average performance improved their outcomes.
- ◆ Several surgeons with consistently poor performance left the profession.

Methods of presenting surgeon performance information

1. League tables (eg. New York State)

Summary information for surgeons 2000-2002

	Cases	no. of deaths	observed mortality rate	expected mortality rate	risk-adjusted mortality rate
Levinsky L	187	11	5.88	1.95	6.80*
Buffalo General	161	11	6.83	2.08	7.44*
Millard-Fillmore	26	0	0.00	1.21	0.00
Lewin A	455	13	2.86	1.80	3.58
Buffalo General	445	13	2.92	1.82	3.62
Millard-Fillmore	10	0	0.00	0.93	0.00

* Risk-adjusted rate is significantly higher than statewide rate

www.health.state.ny.us/nysdoh/heart/pdf/2000-2002_cabg.pdf

2. Bar charts (Pennsylvania)

3. Three-point scale (UK SCTS)

Measuring system performance, and measuring individual performance

“The problem is not bad people; the problem is that the system needs to be made safer” (US Institute of Medicine, *To err is human* Kohn et al. 2000: 49).

But whether or not such a strategy effectively improves patient safety generally, looking *solely* at system errors and hospital-level data can mask individual incompetence (eg. Bristol), and can hinder the appropriate identification and redress of problems with individual clinicians - eg. Qld Health’s approach to investigating the allegations at Bundaberg (see Davies 2005: 165).

Chassin: Individual report cards are best used as a tool to help identify what is wrong: whether systems or individuals

Is there evidence of defensive surgery as a response to report cards?

- A 1996 survey of cardiologists and cardiac surgeons in Pennsylvania provides some support for this objection:
 - ◆ 63% of cardiac surgeon respondents said they were less willing to perform CABG surgery on the most severely ill patients, following public release of individual surgeon data three years earlier.
 - ◆ 59% of cardiologist respondents “reported increased difficulty in finding surgeons willing to perform CABG surgery on severely ill patients who required it”(p 251). Schneider & Epstein (1996).

Drawing general conclusions from the Pennsylvania survey

- But NB: 37% of cardiac surgeon respondents said they were no less willing to take on high-risk patients, following the introduction of surgeon report cards.

This study, by itself, does not support a general claim that high-risk patients cannot find a surgeon prepared to take them on.

- We also need to ask: *which* surgeons are avoiding high-risk patients?

Which surgeons are avoiding high-risk patients?

- Higher risk-adjusted mortality rates tend to be more common amongst surgeons who perform relatively low numbers of CABG operations each year (cf Marshall et al, p. 70, Chassin).
- Thus, when high-risk patients have CABG surgery where surgeon report cards exist, this is more likely done by a surgeon who performs large numbers of these procedures, which usually increases the chances of a successful outcome.

Surgeon report cards could be to the *advantage* of high-risk patients

That some surgeons seem to become more reluctant to operate on high-risk patients in a report card environment does not establish that such patients are disadvantaged:

If the surgeons who begin practising more defensively are also the surgeons who are least proficient at the procedure in question, then it may be to the *advantage* of high-risk patients that those surgeons are now avoiding them.

Per capita *increase* in CABG surgery with high-risk patients in NYS

Peterson's (1998) comprehensive study of high-risk cardiac patient out-migration across New York State from 1987-1992 found

- ◆ there was *no* increase in out-of-state CABG referrals during this period, and the percentage of New Yorkers over 65 who underwent CABG surgery in another state actually *decreased* from 12.5% to 11.3% in this period.
- ◆ older high-risk cardiac patients in New York were *more* likely to receive CABG surgery during 1987-1992 (consistent with trends across the US), and mortality rates had decreased during this time.

High-risk cardiac patients may be overall *better off*, with public reporting

Peterson's (1998) study suggests that high-risk cardiac patients in New York who required CABG surgery were overall *better off* after the introduction of cardiac surgeon report cards, than they were previously.

Anecdotal evidence of defensive surgery

- Anecdotal US and UK evidence that some highly-skilled cardiac surgeons have responded to the advent of report cards by turning away high-risk patients that they would have previously taken on.
- In Australia, some cardiac surgeons have reportedly become reluctant to take on certain high-risk cases, apparently due to concerns that surgeon report cards will inevitably be introduced here.

Studies must be *comparative*

- Anecdotal evidence exists that many surgeons have long avoided operating on high-risk patients, well before individual surgeon report cards were on the horizon: Properly substantiating the defensive surgery objection therefore requires investigating the extent to which the avoidance of high-risk patients *increases*, following the introduction of individual surgeon report cards.
- Such concerns show how important it is to get the risk-adjustment process right (and for surgeons to have confidence in this process).

The relative weight of patients' autonomy-based interests in obtaining risk information

- Patients' autonomy-based interests in obtaining surgeon performance information are not necessarily overridden by the need to prevent high-risk patients from being disadvantaged.
- But patients' autonomy-based interests in obtaining information about medical procedures are not thought justifiably sacrificed for the sake of broader social goals with *other* sorts of currently available risk information (eg. about side-effects and complications of surgery), so why is it any different when the risk information is about individual surgeons' mortality rates? (See Oakley 2007)

Legal issues in public reporting of surgeon-specific performance information

Will surgeon report cards lead to an increase in litigation against surgeons?

- ◆ Chappel v Hart (1998)
- ◆ But, does more public information mean that patients are less able to say they would have chosen otherwise?

Issues for Australia

- Moves to publish comparative surgical performance data in Australia (eg. Victoria, WA), but only of cardiac *units*.
- Should we be publishing for patient choice, patient safety, or public accountability?
- Surgical associations must be actively involved in developing data standards and processes for data collection, validation, analysis and publication.
- Any policy initiative for public reporting of individual surgeon data must be supported by a political commitment to adequate funding.
- It should not need a scandal like Bristol or Bundaberg for such a policy initiative to be taken.

References

- M.R. Chassin, E.L. Hannan, and B.A. DeBuono, “Benefits and Hazards of Reporting Medical Outcomes Publicly”, *New England Journal of Medicine* 334, 1996, pp. 394-8.
- M.R. Chassin, “Achieving and Sustaining Improved Quality: Lessons from New York State and Cardiac Surgery”, *Health Affairs* 41, no. 4, July/August 2002.
- Steve Clarke and Justin Oakley, “Informed Consent and Surgeons’ Performance”, *Journal of Medicine and Philosophy* 29, no. 1, February 2004, pp. 11-35.
- Davies G, *Queensland Public Hospitals Commission of Inquiry – Report*, Queensland State Government: Brisbane, 2005. Also at: www.qphci.qld.gov.au
- L.T. Kohn, J.M. Corrigan & M.S. Donaldson, *To err is human: Building a safer health system*, Institute of Medicine, National Academy Press: Washington, 2000.

References (cont.)

- M.N. Marshall, P.G. Shekelle, R.H. Brook, S. Leatherman, J.W. Owen, *Dying to Know: Public Release of Information about Quality of Health Care*, Los Angeles and London, RAND Corporation/Nuffield Trust, 2000.
- David Neil, Steve Clarke, and Justin Oakley, “Public Reporting of Individual Surgeon Performance Information: United Kingdom Developments and Australian Issues” *Medical Journal of Australia* 181, no. 5, September 2004.
- Justin Oakley, “Evaluating the defensive surgery objection to individual surgeon report cards”, in Steve Clarke & Justin Oakley (eds.), *Informed Consent and Clinician Accountability: The ethics of auditing and reporting surgeon performance*, Cambridge, Cambridge University Press, 2007.
- ED Peterson, et al., “The effects of New York’s bypass surgery provider profiling on access to care and patient outcomes in the elderly”, *Journal of the American College of Cardiology* 32, no. 4, October 1998, pp. 993-9.
- EC Schneider, AM Epstein, “Influence of cardiac-surgery performance reports on referral practices and access to care – a survey of cardiovascular specialists”, *New England Journal of Medicine* 335, no. 4, 25 July 1996, pp. 251-6.