

Should surgeons declare their success rates for the operations they perform?

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During the recent surgical scandal at Bundaberg Base Hospital, a young girl watched helplessly as her father lay dying after a highly questionable medical intervention. At Bristol Royal Infirmary in the mid-1990s, many parents whose children underwent corrective heart surgery learnt that their child did not survive, and a number of these operations were later revealed to have been botched.

These tragic episodes highlight the appalling effects that surgical incompetence can have on patients and their families, when surgeons continue to practise without adequate scrutiny. These cases also provide extreme illustrations of the point that the risks of a surgical procedure depend importantly on the ability of the surgeon who performs it.

Finding good quality information about the performance of individual clinicians, lawyers, builders, and other practitioners is amazingly difficult. Why should it be so much easier to obtain information about the quality of restaurants than it is to find out about the quality of surgeons?

Many surgeons collect information about the outcomes of the operations they perform. This information is often provided to hospitals and to colleagues, for the purposes of peer review. Clearly this does not go far enough – peer review manifestly failed to protect the patients at Bundaberg and Bristol.

There are conclusive ethical arguments for making surgeon performance information available to the public. Releasing this information enables patients to make more informed decisions about surgery, and helps meet surgeons' professional obligations to be accountable to the community for maintaining services at an appropriate standard. It can also improve the safety and quality of surgical care, as public scrutiny provides surgeons with further incentives to improve their performance.

Some surgeons who support greater accountability argue that the overall outcomes for different hospitals is properly made public, or that surgeons' success rates should be published if individual practitioners' names are removed. However, substandard surgical performance will not always show up in hospital-level data, and de-identified practitioner information prevents patients from gaining any idea of the risks particular to their own surgeon.

Others object that report cards showing surgeons' success and failure rates only confuse patients, who tend to value other factors – such as a surgeon's ability to establish a rapport with patients – more highly than information about surgical outcomes. And in a system where patients without private health cover are not usually given a choice about which surgeon is to operate on them, some question whether providing such information serves any useful purpose.

But knowing a surgeon's success rate can be important to a patient, even where they lack a choice of surgeon, as this information can help patients understand the risks of surgery. Consider an analogy. Suppose there was only one effective medication to treat a particular condition you have. This fact would hardly constitute a justification for a doctor not explaining to you the risks of this medication. Overseas research indicates that while a proportion of patients will not use practitioner performance information to choose between surgeons, the majority of patients believe such information is still useful, and ought to be publicly available.

The most common objection to report cards is that they lead surgeons to protect their track records by avoiding patients at highest risk of an unsuccessful outcome. In cardiac surgery, for instance, patients over 65 needing emergency coronary artery bypass surgery are often classified as high-risk, as such patients tend to have higher mortality rates for this procedure than do other patients. If report cards do lead surgeons to practise defensively in these ways, this would certainly be an important ethical concern.

Several US studies suggest that some cardiac surgeons have become more selective after the introduction of report cards in several US states in the early 1990s. Those studies do not however,

make clear whether it is the more skilled or less skilled surgeons who are practising defensively – if it is only the least proficient surgeons who are led by report cards to avoid high-risk patients, such patients may actually be better off under a public reporting system. In any case, overseas research indicates that high-risk cardiac patients are not generally being avoided by surgeons, and that such patients may in some cases actually be welcomed by hospitals and surgeons.

It is also worth remembering that some surgeons have long avoided operating on high-risk patients, well before report cards were first proposed. Surgeons often take pride in successful outcomes, and sometimes feel they have failed when a surgical procedure turns out badly. Also, surgeons often attach considerable significance to their reputation in the eyes of their peers. So, properly substantiating the defensive surgery objection requires investigating the extent to which avoidance of high-risk patients increases, following the introduction of surgeon report cards.

If this concern about defensive surgery were better supported by the evidence, would it be a telling objection to surgeon report cards? It is difficult to justify denying patients and the community access to surgeons' survival and mortality rates in order to ensure that the highest-risk patients are operated upon by the best surgeons. But in any case, it is not clear that any surgeon data publication scheme will inevitably disadvantage high-risk patients. Such data needs to be properly risk-adjusted to enable fair comparisons to be made in light of surgeons' varying patient profiles, and this process needs to be carried out in ways that surgeons themselves and their professional organisations have confidence in.

In an important development that received little media coverage here, the UK Healthcare Commission launched a website earlier this year showing coronary artery bypass graft survival rates for most individual cardiac surgeons in Great Britain. The Commission described this initiative as ushering in a new era of transparency in health care after the problems seen at Bristol and elsewhere. It envisages publishing similar information on other clinicians and surgical specialties in the future. There are strong ethical grounds for reporting this information to the public, and the problems revealed at Bundaberg last year indicate how timely it would be for Australia to consider introducing a similar scheme here.

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