Introduction: Accountability, informed consent and clinician performance information

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Every few years a rogue doctor comes to prominence in the international media. Some, like James Wisheart, the senior paediatric cardiac surgeon at the centre of the Bristol Royal Infirmary Scandal are deemed to be plainly incompetent to perform the operations that they have been undertaking.\(^1\) Others, like Jayant Patel, the surgeon at the centre of the recent scandal at the Bundaberg Base Hospital in Queensland, Australia, appear from the evidence to combine incompetence to perform operations undertaken with a willingness to place their patients in situations of unnecessary risk.\(^2\) The focus of the media on such sensational cases can obscure the fact that there are many less newsworthy, but nevertheless incompetent, physicians practising.\(^3\) According to Atul Gawande, science and technology writer for the *New Yorker*: \(^\) 

In medicine, we all come to know such physicians: the illustrious cardiologist who has slowly gone senile and won’t retire; the long-respected obstetrician with a drinking habit; the surgeon who has somehow lost his touch. (2002, p. 89)

When people are faced with the prospect of having to undergo surgery, they invariably like to be reassured that they will receive a high standard of care. There are many variables that contribute to the determination of the standards of care in a surgical operation. One of them is surgeons’ performance ability. Surgeons vary considerably in their ability to conduct particular operations. Some are outstanding performers, some are adequate performers and some are inadequate. The performance of surgeons and other medical professionals has become the focus of heightened public scrutiny in recent years. While the work of professionals in healthcare and other areas has long been monitored through peer review, highly systematic measures of performance are now being developed, and there is a growing international trend towards the public release of performance information. Healthcare is in the vanguard of this movement, with the
publication in many countries of aggregated information about outcomes in different hospitals for a variety of medical procedures.

There is also an emerging trend towards publishing information about the performance of individual clinicians. This modern trend can be traced back to 1991, when New York State published comparative performance data showing individual cardiac surgeons’ mortality rates for coronary artery bypass graft operations. A few other US states, including Pennsylvania and New Jersey, subsequently published similar information about the performance of cardiac surgeons. After lengthy research, the UK Healthcare Commission launched a publicly accessible website in 2006 showing coronary artery bypass graft survival rates for many individual cardiac surgeons in Great Britain, as well as survival rates for aortic valve replacement surgery conducted by particular surgeons. The Commission has described this initiative as ushering in a new era of transparency, and as a step towards publishing similar information on other clinicians and surgical specialties in the future (Healthcare Commission, 2006).

Moves to publish individual surgeon performance information, presented in ways intended to be useful for patients, have been made largely in response to demands by regulators and the public for greater openness and accountability in healthcare. The public reporting of such information has the potential to enable healthcare regulators and the community to better determine the effectiveness of healthcare funding, and can help to protect patients from avoidable medical and surgical errors. The trend towards publishing clinician performance information has been catalysed by a range of factors, including the rise of the evidence-based medicine movement, which originated in Britain in the 1960s (Parker, this volume), the availability of more sophisticated information technology, the increasing importance given to clinical governance and the development of hospital ‘open disclosure’ policies (Barach and Cantor, this volume).

This collection brings together chapters that examine ethical and social issues concerning the reporting of surgeon performance information. Several of the chapters consider issues of accountability in medicine. Others examine the relation between the publication of surgeon performance information and the doctrine of informed consent. Others look at ethical and social issues raised by the process of reporting surgeon performance information. Public reporting of surgeon performance information is fast becoming an international phenomenon. But there has been a striking lack of sustained analysis and discussion of the ethical implications of this phenomenon. The present collection is intended to help redress this imbalance by providing valuable new perspectives on the ethics of reporting surgeon performance information. The richness and complexity of ethical thinking that has been brought to bear on the ethics of reporting surgeon performance information by our contributors are evident in the chapters contained in this collection.
Ethical arguments for reporting clinician performance information

There is a burgeoning literature in medicine and related fields on healthcare quality and safety, clinical governance and audit, adverse event reporting and evidence-based practice. The public release of individual surgeon performance information – instances of which are commonly known as ‘surgeon report cards’ – is now being discussed and debated by surgeons, professional associations, health administrators, patient support groups and policy makers in a number of countries. A host of complex and interesting ethical questions are raised by the public reporting of healthcare performance information, and particularly, information about individual clinician performance.

Broadly speaking, the publication of performance information about individual surgeons can be supported on three different ethical grounds. First, public reporting of such information enables patients to make better-informed decisions about surgery, and so providing patients with these details can be a way of respecting or enhancing their autonomy, a widely accepted ethical demand in medicine (Beauchamp and Childress, 2001). Second, publishing such information helps fulfil surgeons’ professional obligations to be accountable to the community, by giving the community the means to determine whether surgeons are providing services to the requisite standard, under which the community has typically agreed to grant them a monopoly of expertise. And third, the public release of clinician performance information has the potential to improve the overall quality and safety of surgical care, as public scrutiny provides surgeons with further incentives to improve their performance, and makes it more difficult for substandard individual surgical performance to be concealed within the overall results of a surgical unit. This last ethical argument about quality and safety is sometimes supplemented by an economic argument for the conclusion that the overall quality of surgical care will increase, as better-informed consumers seek out better-performing surgeons and avoid surgeons whose performance is relatively poor. It is important to assess the strength of all three arguments along with other rationales for publishing performance information on individual surgeons. Different rationales may have different implications for what sort of information is to be collected and published, what format the information is to be presented in and what uses it is intended to have.

Autonomy-based arguments, for the conclusion that surgeon performance information should be published to help patients make more informed decisions, seem naturally to support providing patients with access to relatively fine-grained information about significant surgical outcomes – such as each surgeon’s mortality and/or survival rates for a particular procedure. This is because it seems that such information can help patients gain a clearer understanding of the risks involved in undergoing that procedure with a given surgeon (however, see Clarke, this
volume). Providing these sorts of details can also assist patients to make better-informed choices between available surgeons, as well as to make better choices between particular forms of surgery and available non-surgical alternatives.

Autonomy-based arguments for public reporting can be developed through the familiar notion of informed consent. According to the standard account of informed consent, the information patients must be provided with to enable effective informed consent includes information about the significant risks associated with the procedure, along with information that the patient regards as material or relevant to their decision. The risks involved in undergoing a surgical procedure will vary, according to which surgeon performs that procedure. So, providing patients with information about the performance abilities of individual surgeons should be understood as an essential part of the informed consent process (Clarke and Oakley, this volume).

Given the autonomy-based rationale for publishing surgeon performance information, developed through the notion of informed consent, it is particularly important that individual surgeon data are presented accurately and in ways that make such data readily comprehensible by patients. Some patients might regard performance information as relevant to a decision about which surgeon they prefer to carry out a procedure (where a choice of surgeon is available to them), whereas other patients might see this information as material to their decision about whether to have the procedure or to have a non-surgical alternative. In any case, providing this information to patients who value it is clearly part of enabling patients to provide what Faden and Beauchamp (1986, p. 299) call ‘autonomous authorization’ to the procedure, even in cases where the presence or absence of this information would not lead the patient to change their mind about surgery, or about which surgeon they prefer to undertake the procedure.

The second argument for public reporting of surgeon performance data is based on the ethical obligation professionals have to the public, to be accountable for the standard of their work. It is widely accepted that surgeons have a general obligation to be accountable to the community. This obligation is sometimes claimed to be met by the collection of surgeon performance data for internal purposes and traditional peer review. However, the professional accountability argument emphasizes what is owed to the community in return for the monopoly of expertise on the provision of surgical procedures that the community allows the surgical profession to have. Those who become surgeons are selected from the rest of the community and are given extensive training to carry out procedures which others typically are not allowed to perform. On the professional accountability argument, this monopoly of expertise and service provision that surgeons are entrusted with creates a reciprocal obligation for surgeons to allow, and indeed to assist, the community to determine whether the services provided by surgeons are of the required standard. Public reporting is an indispensable means of meeting this obligation.
On the professional accountability argument for publishing clinician performance information, less fine-grained performance information may suffice for identifying clinicians whose performance is substandard. This argument might therefore support public reporting of clinician performance in terms of broad categories – such as whether a clinician’s performance is within or below acceptable standards – rather than in terms of a table comparing each surgeon’s mortality rates. Providing patients with opportunities to discuss the surgical outcomes of practitioners whose performance is within acceptable standards could also become less important on this approach than it might be given the autonomy-based rationale.

The third argument for publishing surgeon performance information holds that public reporting improves the overall quality and safety of surgical care. This argument would naturally seem to support the collection and presentation of fine-grained information about clinician performance – such as the mortality and/or survival rates of each surgeon – to the extent that publishing such information, in a manner enabling meaningful comparisons between surgeons, helps provide surgeons with an additional incentive to improve their performance and to avoid poor performance. This rationale might also be thought to justify moves to rethink the distribution of surgeons, in ways that promote the overall improvement of surgical care.

The quality improvement argument for public reporting has a natural affinity with utilitarian approaches to ethics, where right actions or policies are those that maximize overall utility. Proponents of this form of argument can point to evidence from long-standing public reporting schemes, such as that in New York State, that the publication of individual surgeon performance information leads to a long-term increase in the overall quality of surgical care provided to the community (Peterson et al., 1998; Chassin, 2002; Marshall and Brook, 2002; Hannan et al., 2003). While there is evidence to support this contention, the mechanisms through which public reporting may improve clinician performance have yet to be determined. In New York State, some surgeons with below-average performance improved their outcomes after the advent of public reporting, and several surgeons with consistently poor performance had their operating privileges restricted or left the profession altogether.8

Whether surgeon performance information is to be published to enable more informed patient decisions, to meet clinicians’ professional accountability obligations, to help drive quality improvement by healthcare providers or for some combination of these reasons, bears on how the success or otherwise of publishing such information is to be understood and assessed. Empirical research into the extent to which patients make use of such information, and of the ways that they use it, is crucial to determining the success of public reporting, on both the autonomy-based rationale and the quality improvement argument. However, such studies might be less relevant for the
professional accountability rationale, which can be expected to lead to greater emphasis on research into how regulators and healthcare administrators respond to published information on individual clinician performance. Nevertheless, policy makers in this area will typically be guided by more than one of the three goals we have described.

The types of ethical rationale given for public reporting also bear on the relevance or otherwise of various objections to the publication of such information. For instance, the worry that surgeons protect their report cards from negative outcomes by avoiding high-risk patients is directly relevant to evaluating the utilitarian quality improvement rationale for public reporting, as this worry claims that report cards result in worse outcomes for many patients. However, this concern might be less important on an autonomy-based rationale for public reporting, where better-informed patient decision-making is aimed for, quite apart from any resultant improvement in overall surgical care. Should this concern turn out to be well founded, then utilitarian and autonomy-based arguments may give conflicting directives about whether surgeon-specific performance information ought to be published. In that case, reaching an overall assessment of this question will require determination of the plausibility and relative importance of these approaches, in general. There are analogous debates about the principles of autonomy and beneficence in medical ethics, whose directives will sometimes, but not always, converge and so resolving certain ethical problems in patient care may require settling the proper role and relative strength of these considerations.

Many regard disclosures of performance information on cardiac surgeons as the first step towards providing the public with performance information on other types of surgeons, such as orthopaedic and vascular surgeons, and on other medical professionals, such as obstetricians and cardiologists. Public reporting of individual cardiac surgeon performance information is also widely seen as a test case for professionals in fields other than healthcare, such as lawyers and teachers, and so the issues addressed here also have relevance for many professionals outside medicine. If the publicizing of performance information on individual cardiac surgeons is perceived as being a success, then pressure may soon be brought to bear on lawyers, nurses, accountants and members of many other professions to make individual performance information available to the public.

**Historical background to surgical outcomes reporting**

While the monitoring of surgical outcomes is a topic that has attracted much recent attention, it is also a topic with a rich history. The first person to systematically collect and report data on surgical outcomes is generally agreed to be Florence Nightingale, who is better known as a pioneer of nursing. Nightingale,
who was Britain’s chief military nurse during the Crimean war, instituted a series of reforms in the sanitary conditions of military hospitals and barracks that dramatically reduced mortality rates in the British military. In 1855, 6 months after arriving in Scutari, the main British hospital in the Crimean war, Nightingale’s efforts resulted in a reduction of military hospital mortality rates from 42.7 per cent to just 2.2 per cent (Cohen, 1984, p. 101). As part of her programme of reform of military hospitals in the field and at home, Nightingale employed ‘coxcomb’ diagrams and tables of comparative data to record and publicize mortality rates as well as other outcome measures. Following the success of these reforms, Nightingale started an ambitious campaign for the collection of uniform hospital and surgical statistics in civil hospitals. As a result of her efforts, comparative statistics for hospitals in London and for some British provincial hospitals for the years 1861–1865 were collected and published in the Journal of the Statistical Society of London (Spiegelhalter, 1999, p. 49).

Whereas Nightingale initiated what might be termed an ‘epidemiological’ approach to surgical audit, the US physician Ernest Avery Codman initiated a ‘clinical’ approach to audit (Spiegelhalter, 1999, p. 45). From 1900 onwards, Codman promoted the ‘end-result idea’ (Kaska and Weinstein, 1998). This is:

The common-sense notion that every hospital should follow every patient it treats, long enough to determine whether or not the treatment has been successful, and then to inquire ‘if not, why not?’ with a view to preventing similar failures in the future. (Codman, 1934, pp. v–xl)

Although this idea seems commonsensical today, at the beginning of the twentieth century it was highly controversial, and Codman drew attention to its controversial implications by resigning from the Massachusetts General Hospital in protest at the seniority system of promotion, which he held to be incompatible with the end-result idea (Kaska and Weinstein, 1998).

In 1911 Codman founded the private Codman Hospital to develop and promote the end-result idea, bypassing the Massachusetts medical system (Kaska and Weinstein, 1998). Unlike Nightingale, who preferred to work behind the scenes, Codman courted controversy. In 1915 he unveiled an 8-foot high cartoon at a public meeting, satirizing the Boston medical establishment as using unproven techniques to acquire golden eggs (large fees) from residents of the Back Bay area in Boston, who are depicted as an ostrich with its head in the sand, ignorant of the quality of available physicians and the efficacy of their techniques. Codman was subsequently sacked as a Harvard instructor and in 1918 his hospital closed (Spiegelhalter, 1999, p. 53). Today, Codman’s ideas find a more receptive audience and his reputation has been much restored. Since 1997 the US Joint Commission on Accreditation of Health Care Organizations (2006) has awarded annual Ernest Amory Codman Awards for ‘. . . achievement by organizations and individuals in the use of process and outcomes measures to improve organization performance and quality of care’.
Modern developments

The efforts made by Nightingale and Codman, in collecting and publicizing healthcare performance information, were exceptional in a long era in which performance information was not systematically collected or disseminated. It is only in the last 15 years that we have seen the emergence of a new trend in which performance information is increasingly collected and reported to the public (particularly in the United States and the United Kingdom). In the opinion of Marshall et al. (2003), it is inevitable that this trend will continue.

In the United States there is a plethora of performance information that has recently been made available, produced by state governments, employers, consumer advocacy groups, the media and private enterprise. Perhaps the most characteristic feature of contemporary performance measurement in the United States is its diversity. Information is now available about the comparative performance of hospitals, health insurance plans and individual physicians (Marshall et al., 2003). Examples include Healthscope, a service provided by the Pacific Business Group on Health, a consortium of Californian employers who aim to improve the quality of health care for their employees and Californian residents in general (www.healthscope.org), and Healthgrades, a private company that sells comparative information on hospitals (www.healthgrades.com). Perhaps, however, the best known and most widely discussed initiative in American performance measurement is the New York State Department of Health (2005a) ‘report cards’ on coronary artery bypass graft operations. These reports, which have been issued since 1991, compare the risk-adjusted mortality rates of individual surgeons in New York State who conduct this form of heart surgery.

Cardiac surgeons’ mortality rates for coronary artery graft surgery (CABG) have been at the forefront of individual clinician performance reporting, in part because this operation is one of the most commonly performed operative procedures in the Western world today (Marasco and Ibrahim, this volume). Extensive clinical databases have been created that monitor patient outcomes for CABG in different hospitals. These databases concentrated on mortality rates, because mortality is an outcome that can be accurately defined and verified, which helps with making reliable comparisons between different healthcare providers. These clinical databases provided the foundation for the development of more sophisticated databases for the monitoring and public reporting of individual cardiac surgeons’ outcomes for this procedure.

There have also been developments in public reporting of healthcare outcomes in Canada. For example, a comprehensive report showing hospital-specific outcomes for various cardiac procedures (including CABG surgery) in Ontario was published in 1999 by the Institute for Clinical Evaluative Sciences, Toronto, and some Canadian hospitals have websites reporting their outcomes for various procedures. These initiatives are aimed primarily at improving the
accountability of Canada’s national health system by making the use of public funds more transparent, and so less emphasis is placed by these reports on facilitating patient choice between different hospitals. Nevertheless, there is evidence that some healthcare providers have responded to public reporting of hospital outcomes by developing various quality improvement activities (Tu and Cameron, 2003; Morris and Zelmer, 2005).

In the United Kingdom, performance measurement has been developed in a much more centralized and coordinated way than in the United States. Unlike the laissez-faire United States experience, major developments in performance measurement in Britain have resulted mostly from shifts in government policy. Smith (2005) identifies three phases in the recent history of healthcare performance measurement in the United Kingdom, the ‘command-and-control era’, the ‘market era’ and the ‘regulatory era’. In the command-and-control era of the 1980s, the modest amount of performance information collected was gathered for the purposes of enabling decision-making in a centralized National Health Service (NHS). In the early 1990s, the prevailing government ideology of centralized command was replaced by one of attempting to emulate the private sector. Performance indicators were developed that were intended to further the functioning of an ersatz market, in which competition between health authorities was engendered in order to enable market mechanisms to function so as to improve the quality and efficiency of health services.

Following the election of the Blair Labour Government in 1997, a new emphasis on establishing formal mechanisms to ensure the accountability of health authorities brought performance measurement to centre stage in healthcare policy. Currently, every NHS organization is rated on a scale between zero and three stars on the basis of a number of performance measures (Smith, 2005, p. 216). A huge impetus for this turn to accountability in medicine was provided by the paediatric cardiac surgery scandal at Bristol Royal Infirmary from the late 1980s to the mid-1990s, and the subsequent government Inquiry chaired by Sir Ian Kennedy. During this period, two paediatric cardiac surgeons at Bristol Royal Infirmary had particularly high mortality rates for certain surgical procedures carried out on infants with congenital heart defects, with the mortality rates for these surgeons at one stage being five to six times the UK average for those procedures. These problems were not widely known (and the children’s parents were unaware of them), until anaesthetist Dr Stephen Bolsin, who had been collecting outcome data on procedures performed by these surgeons, presented these data to hospital management. However, faced with a lack of intervention by the hospital Chief Executive, Dr Bolsin took his concerns to the Department of Health, and then to the UK General Medical Council (GMC), who initiated an Inquiry. The GMC inquiry found the surgeons guilty of serious professional misconduct, and one of them was consequently deregistered (see Bolsin, 1998; Bolsin and Freestone, this volume). Sir Ian Kennedy’s 2001 Report from the
subsequent government inquiry located the source of the Bristol tragedy in the insular and conformist ‘club culture’ of the NHS and argued for a sea change in the culture of medicine in the United Kingdom (Neil et al., 2004, p. 266).

Although the main trend in British performance measurement has been the development of performance indicators at the institutional level, there have been some recent initiatives in the dissemination of individual level performance measurement. The Bristol Inquiry did not specifically recommend the publication of surgeon-specific performance information, but this Inquiry undoubtedly accelerated moves to make such information available to patients (see Smith, 1998). In January 2002 the then Secretary of Health, Alan Milburn, announced an agreement with the Society of Cardiothoracic Surgeons (SCTS) to publish mortality rates for all British cardiothoracic surgeons. He also indicated that more information regarding individual consultant outcomes would be made available over time (Neil et al., 2004, p. 266). In March 2005, The Guardian used Freedom of Information legislation to obtain surgeon-specific data on CABG mortality rates (not all of which were risk adjusted) for many UK cardiac surgeons, which the newspaper published during that month. In 2006 we saw the launch of the UK Healthcare Commission website (which they jointly developed with the SCTS) showing surgeon-specific survival rates for CABG and aortic valve replacements, for UK cardiac surgeons. The Commission envisages broadening this initiative to other surgical specialties in the future. Also, the NHS has announced an internal reporting system to identify surgeons who spend too long on certain procedures,15 and the UK Royal College of General Practitioners is proposing to introduce a scheme whereby clinics are rated by an expert panel on a three-star scale, according to the level of service they provide for patients, and clinics will be encouraged to publicize their ratings.16

So far, in Australia, there have been only tentative steps in the development of clinician performance measurement and reporting. In 2003, the Victorian Department of Human Services began to publish annual reports on public hospital cardiac units (in which unit-level data are de-identified) (Reid et al., 2005). In Western Australia a state-wide audit of surgical mortality has been established (based on a modified version of an established Scottish model) (Reid et al., 2005). Surgeon-specific mortality rates are to be published, but individual surgeons will not be identified. Participation in this audit is voluntary, but high (96%). The Royal Australasian College of Surgeons has endorsed the Western Australian audit as a model for future surgical mortality audit in Australia and New Zealand (Thompson et al., 2005), and this model has now been adopted in South Australia, Tasmania, Queensland and New South Wales. Also, the Australian Commission for Safety and Quality in Health Care is developing a National Cardiac Procedures Register, to record de-identified, risk-adjusted information on the outcomes of a number of procedures, including coronary artery bypass graft surgery (Neil et al., 2004, p. 267). And, a report by the Australian Government’s Regulation Taskforce has recently