EDITORIAL

Public reporting of individual surgeons' outcomes in the UK

In December 2012, the UK National Health Service (NHS) announced that outcomes from procedures in 10 medical and surgical specialties would be published in 2013. Each individual surgeon's results would be published rather than those of a department. The standards would be set and the data collected by the medical profession through specialty associations. The British Association of Urological Surgeons (BAUS) was required to produce data on a representative procedure. Nephrectomy was chosen because it is performed by roughly 40% of urologists and BAUS had a voluntary nephrectomy registry in place since 2001. The outcomes included length of stay, transfusion, complications, mortality, and conversion from laparoscopic to open surgery.

British urologists who carry out nephrectomies were asked to submit their own data within a tight 2-month time frame. A total of 6042 operations were reported, representing 76% of all nephrectomies. Over 7500 (> 90%) have been reported for 2013. The results for 2012 and 2013 can be found on the BAUS website: http://www.baus.org.uk/patients/surgical_outcomes/index. British vascular surgeons reported their outcomes in a format that allowed the notorious British press to compare mortality rates using the crudest form of statistical analysis: 'NHS Surgeons with Highest Death Rates Named' read one. Fortunately, journalists did not find anything newsworthy in the nephrectomy data. The data has a number of limitations, chiefly the lack of a quality assurance system to verify the accuracy of data entered by surgeons about their own practice. Nevertheless, some important data, such as mortality, re-admission, and length of stay, can be easily verified.

What are the effects of public reporting of outcomes? Urologists doing very few nephrectomies might be inclined to stop altogether and some may be more likely to refer complex cases. Centralization of nephrectomies in fewer hospitals, it could be argued, ought to be good for patients. On the other hand, if there is not enough information regarding case mix, reporting might lead to inappropriate conclusions being reached. Some urologists might turn down high risk patients simply for fear of being labelled 'Doctor Death'.

Public reporting of outcomes for urologists in Canada and the United States has yet to be carried out to the same extent. The AUA Quality Registry (AQUA) is due to start in 2015 and aims to collect data on prostate cancer care by practice. Ultimately, reimbursement from Medicare and possibly insurance companies will be affected by the data entered into the registry. There is no plan to publish the data publicly or to assess individual urologists. The recent publication of gifts made by industry to doctors in the United States through the Sunshine Act has profoundly changed the behavior of sales representatives but has not produced any meaningful data about the care patients receive. Most data about physicians is produced by commercial websites and is composed chiefly of patient feedback with little or no objective data provided. Data reported by urologists, even in peer-reviewed publications, tends to be heavily biased. Selective publication is one of the most common flaws in our literature, often leading to unrealistic patient expectations.

Most of us do not need public reporting in order to change our practice – we respond to the direct feedback from patients and colleagues as well as changes in referral patterns. Clearly, some surgeons get consistently good results and others should stop carrying out complex operations altogether. Unfortunately, not all urologists have the insight to recognize their limitations. Furthermore, patients sometimes feel they have no choice in their urologist due to geography, insurance status, or reticence to ask for a second opinion. Public reporting of outcomes ideally would help inform patients to make decisions in an objective way.

What next? The British program is expanding. Radical prostatectomy, PCNL, and procedures for stress urinary incontinence are due to be published in 2015, then cystectomy in 2016. There are inherent problems with each of these in terms of outcome measures. For example, if a patient has a smooth perioperative course but has a local recurrence and incontinence following a radical prostatectomy, it must be deemed a failure (albeit a safe one).

Traditionally, the British public have had a very high level of trust in doctors, but some high-profile cases have shaken that trust. We now are obliged to demonstrate that we are safe and effective surgeons. The scrutiny of our work by is only likely to increase with time, no matter where we practice.

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