Surgeon records in the public domain

The United Kingdom government has announced its intention to publish records of orthopaedic surgeons practicing in the country in relation to major joint arthroplasty. This follows collaboration between the British Orthopaedic Association and a previous government in the establishment of the National Joint Registry (NJR). Since its inception, the NJR has confirmed that hip and knee replacement are two of the most effective ways in which valuable NHS resources can be spent and two of the most consistently effective operations available.

The public release of outcomes is established and accepted in parts of Scandinavia, but it is impossible in Australia, where the National Joint Registry is administered entirely by the Australian Orthopaedic Association. The assertion that public funding has provided the registry service and the public therefore has an entitlement to access results is perhaps disingenuous, since the provision of medical services by the public sector is the default situation in the United Kingdom and parts of Scandinavia, whereas the private sector dominates the provision of healthcare in Australia, the United States, and in many other countries. It is very difficult and uncommon for a surgeon to practice independently in the United Kingdom, in contradistinction with most other professionals. The government in the UK therefore has a monopoly employer status and insists, on that basis, that results should be placed in the public domain.

On 14th March 2013 the Minister of Health in the UK was reported by the media as saying that he intends to ‘name and shame’ surgeons who do not allow their results to be publicised. This may be pre-judging the outcome of this initiative -or demonstrating ‘prejudice’, in assuming that publicising data will be for the greater good and that shame should be associated with withholding data. It is not known if public dissemination of such information is likely to be a good thing, and ‘shame’ should not be attached to sincerely held beliefs in a democracy.

At the time of the original discussions between the British Orthopaedic Association and the Department of Health in the UK in 2003 regarding the establishment of the National Joint Register, the DoH representatives indicated that there was ‘no intention at this stage’ to put results in the public domain. This assertion carried a degree of ambiguity. The current position of the UK government is that only mortality figures will be released. A cynic might query why a mid-term administration should seek to tackle this non-issue. There is strong evidence that mortality rates after joint replacement are consistently low and almost completely unrelated to the quality of surgery. Those patients who do succumb are far more likely to be the victims of social deprivation, poor medical health or care in a unit that is less than optimally equipped to undertake such work. In consequence mortality following joint arthroplasty is dependent on a range of factors almost all of which are beyond the control and unrelated to the expertise of the surgeon. Indeed, this journal has published standardised mortality ratios following hip replacement which indicate an enhanced likelihood of survival compared with the general population (1).

Far more information is acquired from assessment of revision rates, which are also available in the NJR figures, and it may be anticipated that publication of this information is the next step in the process. However, publication of surgeon specific data may prove detrimental to the care provided through the NHS. As all surgeons know, the revision rate of an experienced and skilled hip surgeon with a complex arthroplasty practice may well be greater at five or 10 years than that of another surgeon in his or her department whose primary skills lie in other subspecialties and who generally only undertakes straightforward joint replacements. While great efforts have been made to correlate revision rates with pre-existing comorbidities and other confounding factors, the interpretation of results remains difficult even within a small group of surgeons within an academic department, and will be almost impossible for the public at large to understand. Risk stratification of the complexity of the case mix remains an unresolved challenge.

Therefore, the apparent intention to produce ‘league tables’ will, in the public eye at least, create an impression of stratification from ‘best to worst’ within each hospital and within each region which is likely to be unrepresentative and misleading. A further problem arises, at least within the UK, regarding the motives of the political parties. Reservations about public dissemination of information in this way are probably justifiable, and an extension of the information released to the public from mortality rates to revision rates (should this occur) may be a cause for concern.
Some might suggest that it is in a patient’s interest for information to be released about surgeons, and that this can lead to improved patient care. However, this is difficult to validate. Surgeons are human, too. If a surgeon is faced with a patient who might benefit from a total hip replacement but whose age or comorbidities suggest that the risk might be higher than normal, what is that surgeon to do? A decision not to help the patient would ensure the surgeon’s registry dataset remained unblemished but at the cost of vocational commitment. An improvement in the data produced by registries only applies to operations undertaken, and takes no account of those waiting in the community who have been denied the procedure and those who have been denied one of the most effective medical interventions ever devised. Patient care in the community may therefore suffer.

Publication of mortality data following cardiac surgery in the UK already occurs, but mortality ‘per se’ is not a useful discriminant in analysing joint replacement practice. Revision rates may be, but they are very difficult indeed to interpret usefully. The media in the UK may find it difficult to approach the matter objectively and constructively for the benefit of all, given the complexities involved.

The value of information on joint replacement outcomes would lie in providing reassurance that surgeons and hospital services are meeting acknowledged standards of care. This would be commendable. However the difficulty in objectively interpreting available data will make it almost impossible to provide this reassurance. There must then be a concern about how politicians, administrators and patients will misinterpret and misuse the data.

Robert F. Spencer
Editor-in-Chief

Richard N. Villar
The Villar Bajwa Practice, Cambridge - UK

Richard E. Field
London Orthopaedic Centre, Epsom, Surrey - UK

Ian D. Learmonth
Advisory Editor

REFERENCES