Discussion document: Better data – the benefits to the profession and the public

Thank you for the invitation to provide feedback on the above discussion document. We applaud the initiative of the Medical Council in raising this issue for discussion with stakeholders in the health sector and the New Zealand Society of Anaesthetists (NZSA) welcomes the opportunity to give our views and considerations on this paper.

About NZSA

The New Zealand Society of Anaesthetists Inc., (NZSA) is a professional medical education society established in 1948. It represents almost 500 medical anaesthetists in New Zealand and works to foster education and research into anaesthesia, and support the professional interests of its members. Members include specialist anaesthetists in public and private practice, and trainee anaesthetists. NZSA is a member society of the World Federation of Societies of Anaesthesiologists (WFSA) and is represented at Executive level on the WFSA.

Introduction

Our primary interest with regard to the discussion document is in ensuring that the gathering of patient outcome data, and any subsequent publication of this data, is done only if there is demonstrable value to both the medical profession and health stakeholders. We support the gathering of data for further education purposes in particular, but we caution that this needs to be done in an appropriate way, and this submission will demonstrate how this is already being done successfully in anaesthesia.

This submission will also outline a number of other points we find concerning, and give a briefing of an Australasian anaesthesia data collection programme we suggest is a leader and useful model in this area.

We will refer to the data as the gathering of “patient outcome data”. We believe the term “performance outcome data” unduly emphasizes the performance of a medical professional, when in fact the data may not be reflective of the doctor’s performance. The outcome may be influenced by a number of factors, including the condition of the patient prior to the procedure, and, we will argue later in this submission, from the care of a multidisciplinary team rather than an individual. We agree wholeheartedly with Minister Dr. Jonathan Coleman’s opinion that medicine is now “a team sport”.

We support and endorse the submissions of the New Zealand Medical Association and the New Zealand National Committee of Australian and New Zealand College of Anaesthetists (NZNC-ANZCA) who have made similar comments on this topic.

Purpose of collecting patient outcome data

We agree with MCNZ that it is important to examine the basis for both collecting patient outcome data, and subsequently publicizing it. This consultation process has been prompted by media requests, via the
New Zealand Society of Anaesthetists
(Incorporated)

Official Information Act, for surgical outcome data. We contend that there needs to be a sound purpose for collecting patient outcome data beyond it being as a response to media, who, along with the public, are at risk of interpreting the information out of context, in comparison to how the medical profession would interpret it. We discuss context issues further on page three of this submission.

We do support the collection of data where it can yield useful information for learning and addressing failures. As detailed in the NZNC-ANZCA submission, the causes of some major failings in healthcare have been identified as systematic problems. If the collection of data is based on units, areas of service or District Health Boards, this would provide useful indicators of where problems are, for example, identifying variance among DHBs.

We support data collection where it can be used for the on-going education of medical professionals, with the aim of reducing risks and improving outcomes for the future as outlined below.

Anaesthesia data collection – webAIRS

One of the key roles of the NZSA is to provide continuing education opportunities for our members to keep anaesthetists up-to-date with the latest research, developments and outcomes in anaesthesia. We do this by hosting and supporting meetings and conferences in both New Zealand and Australia, where our members hear presentations from leading international anaesthetists.

A further example of our support for data collection is our involvement in the anaesthetic data collection programme, webAIRS1, which we encourage New Zealand hospitals and anaesthetists to join. webAIRS is an incident monitoring software programme, which collates de-identified information with the ultimate aim of reducing risk and improving quality and safety for future anaesthesia.

Anaesthetic incident monitoring has taken place in Australia and New Zealand since the 1980’s. In 2010 the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC), which includes the NZSA, ANZCA and the Australian Society of Anaesthetists launched webAIRS.

webAIRS enables a de-identified subset of the data to be forwarded to a bi-national registry. It does not affect existing hospital incident recording and management systems. The registry is used to work out strategies, at a bi-national level, for preventing such incidents in the future. The project has qualified privilege by the Ministry of Health2 and, in Australia, the Department of Health and Ageing, to collect and protect the data.

In addition to this, ANZTADC communicates closely with stakeholders operating similar registries throughout the world. This includes the Anesthesia Quality in USA and organisations in Canada, South America, Europe, Africa and Asia.

There are currently 25 registered webAIRS sites in New Zealand and Australia. webAIRS has developed a knowledge base of learnings for some of the many complex but sometimes rare clinical situations that anaesthetists are required to solve during clinical practice. This encourages consistency in decision processes and means anaesthetists can demonstrate they follow an accepted pathway to solving anaesthetic events.

---

1 webAIRS www.anztadc.net

NZSA… Representing, Supporting and Promoting NZ Anaesthetists since 1948

Central House, Level 1, 26 Brandon Street, Wellington
PO Box 10-691, Wellington 6143, Ph (04) 494-0124 Fax (04) 494-0125 Email nzsa@anaesthesia.org.nz
webAIRS regularly gives updates of analysis and results in the NZSA and ASA magazines, the ANZCA Bulletin, and presentations to international meetings. This year it was presented to the ANZCA Annual Scientific Meeting, and will be presented to the ASA and NZSA NSC, in Darwin in September.

Anaesthesia data collection – POMRC

Anesthesia data is also fed to the Perioperative Mortality Review Committee (POMRO), which reviews and reports on perioperative deaths with the aim of reducing deaths and supporting quality improvement in the health sector. The committee advises the Health Quality and Safety Commission on matters related to perioperative mortality and morbidity outcomes, with recommendations to assist with improving quality and safety.

Information for the public

We note the work and recommendations of former Health and Disability Commissioner Dr Ron Paterson (current Ombudsman), on increasing transparency in the medical profession in his report “The Good Doctor – what patients want”. Dr Paterson notes that patients expect their doctors to be competent, have maintained their skills and be up-to-date in their medical knowledge. We agree with his recommendations 1, 2 and 3 that patients should be able to access details of local doctors’ registration and qualifications, to give some reassurance that steps are taken to credential doctors and provide transparency to patients.

The fourth recommendation “Medical Colleges and specialty societies should follow the example of the SCS and collect, analyze and publish data showing the quality of care provided by practitioner members”, is more problematic to us. While we have a number of concerns, to mitigate these, we suggest that any such system would be developed carefully over time and correctly analyzed with the input of relevant clinicians to ensure the collection of valid data that would be useful.

Our concerns

Multidisciplinary approach

As mentioned in our introduction we would be concerned if data gathered and subsequently publicized gave the misleading impression that the outcome of a medical procedure is dependent on the work of one medical professional or clinician. Our clinicians work in multidisciplinary teams in their care of patients. As has been found in a number of cases investigated by the Health and Disciplinary Commissioner, failures can occur across teams. For this reason we believe reporting data on individual performance can be misleading and out of context.

There are several publications that support a multidisciplinary approach to patient care.

Anaesthesia supports the World Health Organization’s Surgical Safety Checklist, which has a goal of improving surgical safety. The implementation manual for this states that the operating team “is all persons involved” and that “each plays a role in ensuring safety and success”, emphasizing the multidisciplinary team approach.

---

3 webAIRS reports, New Zealand Anaesthesia, Issues 38, 40 & 41.
4 ASA and NZSA NSC. Darwin, September, 2015 www.aomevents.com/asa2015/Programme
New Zealand Society of Anaesthetists
(Incorporated)

Another paper which supports the multidisciplinary approach, *Publication of surgical outcomes – data: whose team are we on?* says creating a “culture of patient safety” is usually understood to mean strengthening the team, encouraging shared responsibility, and striving for systems that improve complex decision making … to prevent dominance by one (fallible) person." The report also encouraged “blame free reporting”.

We also draw your attention to the International Journal Surgery review (2015) of implementation, controversies and the potential impact on surgical training in relation to surgeon specific outcome data. It said “Focusing outcomes on the responsible surgeon also ignores the impact of the wider team involved in patient care, including anaesthetists, critical care, nursing staff and allied health providers involved.”

American surgeon, writer, and public health researcher, Atul Gawande backed the practice of a team approach at a Health Quality and Safety Commission meeting in May in Wellington, with his well-known address “Cowboys versus Pit-stop crews”. In it he stresses the health sector should be training efficient, coordinated crews with the primary focus on patient care rather than an old model of “cowboys” working in isolation. He encourages health to be delivered around teams that focus on improving care outcomes and the health of the community.

**Risk-averse environment**

A successful data collection programme is dependent on clinicians feeling safe and comfortable providing information about their outcomes, in particular adverse events. We have concerns that if an environment was created where there was increased risk that data would be misinterpreted or used out of context, this would create fear for doctors. Effects of this fear could produce a risk-averse environment rather than the environment of improvement that we encourage. A change of environment in this way would undermine the purpose of gathering data to improve future outcomes.

Another risk-averse effect from the reporting of patient outcome data, or surgeon specific data as it is known in the United Kingdom, is fewer cases being performed by trainees, for fear of a negative outcome on their record. This was noted in a report by the English Royal College of Surgeons, which also suggested the system dis-incentivized consultants to provide surgical training.

With any reporting on individual doctor’s performance in relation to patient outcomes, we also have concerns that clinicians will opt to take less complicated cases, to avoid areas of practice where there are risks of poorer outcomes. We would expect this consequence to have workforce implications for medical teams and possibly reduce access for patients.

**Conclusion**

We support data collection where the data can be used for the on-going education of anaesthetists to reduce risks and improve outcomes for the future. We believe there needs to be a sound basis for data collection and dissemination to the public. We don’t believe demand from media or the public are, on their own, a sound basis for such a proposed program.

We agree with improved openness and accountability to the public in medical professions, but recommend clinician and anaesthetist input into any data collection programme to ensure its validity and appropriate effects.

---


use of the data. We recommend webAIRS as a successful model to look at as part of any process being developed.

We have concerns that raw data could be misinterpreted, and we encourage data based on team outcomes rather than individualized clinicians.

We have outlined a number of concerns about the release of performance and outcome data and would find it difficult to support this proposal unless these concerns are addressed satisfactorily. If this process was to develop further, to mitigate our concerns we suggest a stringent risk analysis of any data collection programme with the involvement of clinicians to ensure that it would not undermine the current process of gathering information from adverse events.

Thank you for the opportunity to submit on this important topic. I am happy to discuss this submission further. Please feel free to contact me at president@anaesthesia.org.nz to arrange a meeting or conversation.

Yours faithfully,

E W (Ted) Hughes

Dr Ted Hughes
President

References:

1. webAIRS www.anztaadc.net
3. webAIRS reports, New Zealand Anaesthesia, Issues 38, 40 and 41.
4. ASA and NZSA NSC, Darwin, September, 2015 www.aomevents.com/asa2015/Programme