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Against the informed consent argument for surgeon report cards

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The publication of outcomes information, or ‘report cards’, for individual surgeons can be argued for on three distinct grounds. One kind of argument appeals to healthcare quality, and focuses on the value of individual performance auditing for patient safety and for an evidence-based approach to best practice. A second kind of argument constructs the patient as a healthcare ‘consumer’ and appeals to a notion of consumer rights, such that patients have a right to comparative information about the healthcare products and services that they consume. Some proponents of this kind of argument believe that enabling patients to be more informed consumers will introduce productive market incentives into the healthcare system. A third kind of argument appeals to respect for patient autonomy and the requirement of informed consent to any medical intervention. I will refer to these arguments, respectively, as ‘the argument from quality’, ‘the argument from consumer sovereignty’ and ‘the argument from informed consent’. In advocating the publication of surgeon-specific outcomes data, it matters which argument we take to be fundamental, because the basic rationale for having surgeon-specific report cards has implications for the form, content and funding of such a system.

With respect to the argument from quality, the literature examining the effect of public reporting of comparative performance information on healthcare quality presents an increasingly compelling argument that such reporting is necessary for sustainable quality improvement (Chassin, 2002; Marshall *et al.*, 2002). From this perspective, the value of surgeon-specific performance data is that it assists with a sophisticated analysis of the factors contributing to medical errors. As Mark Chassin (1996) puts it:

Some of the new tools of quality improvement permit us to understand much better how errors creep into clinical practice. This kind of analysis, adapted from industrial models, involves studying in detail all the steps involved in providing a particular kind

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of care. It does not seek to identify errors in order to assign blame, but instead assumes that faulty systems of care are very often responsible for errors. Fixing systems by reducing unwarranted variations in the provision of care can be much more effective in reducing errors than punishing people.

The argument from quality and the argument from consumer sovereignty are not necessarily incompatible. The quality approach focuses on the technical analysis of the sources of error in complex medical systems. The argument from consumer sovereignty sees the value of surgeons' report cards, not in terms of the analytical value of the data, but as a means of introducing incentives that reward doctors and institutions for good outcomes. Whether the market effects of report cards for medical service providers advances or hinders the goal of quality is a substantive empirical question, and the available evidence is mixed.

UK government reforms requiring patients to be given a choice of hospitals provide a case in point. The University College London Hospitals Trust announced, in December 2005, that it would advertise for patients by claiming that it has the lowest death rates in the National Health Service (Templeton, 2005). The claim is based on the findings of the independent health research group Dr Foster. This kind of initiative aims to force hospitals to compete on the grounds of safety and quality. However, it may turn out that linking surgeons' 'market value' to their mortality rates may introduce counter-productive disincentives into the system. For instance, there is some evidence from New York that cardiac surgeons are turning away some high-risk patients who might benefit from surgery, in order to protect their published mortality rates (Kolker, 2005). Similarly, Sir Bruce Keogh, president-elect of the Society of Cardiothoracic Surgeons, has said that:

There is absolutely no doubt in my mind that the publication of mortality data in England has had a negative effect on surgeons taking on high-risk cases . . . There will, inevitably, be some people who don't get an operation now, who might have got one in the past. (Fracassini and Nutt, 2005)

I am sceptical about the idea that consumer preference, informed by access to report cards, could be an effective mechanism for driving improvements in surgical safety. However, the question of whether market mechanisms can promote healthcare quality is not the subject of this paper. Rather, this paper examines the argument from informed consent.

The argument from informed consent is important because it is independent of the argument from quality. The argument from informed consent attempts to sidestep questions about the actual effects that report cards will have on the healthcare system, by arguing that access to surgeon-specific performance information falls within the ambit of an existing right. This is not an argument that rests on empirical claims about the costs and benefits of

performance reporting, but instead appeals directly to a general principle of medical ethics – the principle of respect for patient autonomy.

I will argue that the informed consent argument for surgeon report cards is actually fairly weak; too weak in fact to provide a sufficient justification for developing a surgeon-specific outcomes reporting system. The right to such information cannot be derived from the general requirement to respect patient autonomy. Consequently, calls for a report card system need to be justified in terms of their value for realizing improvements in quality and safety standards.

The idea that, as patients, we have a right to know about our surgeon's experience and success rates has an immediate appeal. It is the kind of demand that follows naturally in the wake of revelations of clinical incompetence, and indeed it did follow in the wake of the Bristol Royal Infirmary scandal. The UK national paper, *The Express*, offered one of the more shrill responses to the findings of the Bristol Royal Infirmary Inquiry (Parker, 2001):

Not until we have eradicated a culture in which doctors can be more interested in furthering their ambitions than in telling the truth about their success rate or a patient's chances, will we prevent another scandal like that at Bristol Royal infirmary happening again.

It is important, however, not to conflate our right, as patients, to be protected from medical negligence and incompetence, with a proposed right to have fine-grained comparative performance information about all surgeons.

The argument from informed consent has been developed primarily by Steve Clarke and Justin Oakley in their paper 'Informed consent and surgeons' performance' (2004). My critique of the argument from informed consent will focus on Clarke and Oakley's paper. Their basic strategy is very straightforward. It is uncontroversial, under the doctrine of informed consent, that the reasonably foreseeable risks of an operation must be disclosed to patients in the consent process. Clarke and Oakley contend that relevant risk information includes 'information about the ability of available surgeons to perform the operation in question' (2004, p. 12):

Our main point is simple and, we think, very hard to deny. The risks that should be disclosed to patients are the risks that we can reasonably expect that patients will face when undergoing an operation. These risks will vary, *inter alia*, according to the level of ability of the surgeons who are available to perform that operation. So, information about the performance ability of surgeons is a necessary component of the disclosure of the reasonably foreseeable risks of a surgical intervention. And, as the disclosure of the reasonably foreseeable risks of a surgical intervention is a necessary requirement for the provision of effective informed consent, the disclosure of information about the performance ability of available surgeons is a necessary requirement for the provision of effective informed consent to a surgical intervention. (2004, p. 12)

Clarke and Oakley stress that they accept the 'received view' that the moral principle which grounds the doctrine of informed consent is respect for patient

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autonomy. They insist that the availability of surgeon report cards will give patients more autonomy with respect to decisions about surgery:

We best uphold a patient's autonomy by enabling that patient to properly understand the risks that they are exposing themselves to when choosing to be operated on by a particular surgeon. (2004, p. 13)

There are two problems with this argument. The first concerns Clarke and Oakley's use of the notion of 'disclosure'. A medical practitioner's obligation to disclose information applies to information that she knows or should know – crucially, information that is *available*. Standard obligations of disclosure cannot be extended to generate an obligation to *discover* information that is not presently known. Clarke and Oakley expand the obligation of disclosure in a way that has counter-intuitive consequences. The second problem with their argument is that it fails to respect a formal constraint on any argument from autonomy – namely, that any substantive right derived from the principle of respect for autonomy must be universalisable. I will consider these problems in turn.

Clarke and Oakley point out that, where it is available, stratified risk information is more relevant than very general risk information. For instance, a risk algorithm such as the European System for Cardiac Operative Risk Evaluation Score (EuroSCORE) takes into account a range of factors in determining percentage predicted mortality for cardiac surgery. These risk factors include age, gender, history of pulmonary disease, previous cardiac surgery, unstable angina as well as 14 other criteria. If you were considering consenting to a coronary artery bypass graft, you should be told your mortality risk as predicted by an algorithm such as EuroSCORE, rather than merely being told less 'personalized' information, such as the average mortality rate for all cardiac patients. Clarke and Oakley tell us that 'we ought to provide more fine-grained information where it is available, because it more closely approximates the actual probability of the relevant possible event' (2004, p. 14).

The phrase 'where it is available' is misleading in this context. Clarke and Oakley recognize that 'a complete list of factors that can potentially affect the probability that a risk may materialize would be extremely long, if not infinite' and that this would be 'impractical if not impossible' (2004, p. 15). Having noted, on pain of absurdity, that some restrictions must apply to the scope of the disclosure obligation Clarke and Oakley do not give any sustained consideration to the difficult question of how the appropriate boundary between obligatory and supererogatory disclosure should be drawn. Instead, they assert that a surgeon's level of performance is a factor that many patients would consider important. They further claim that:

Commonly, surgeons already maintain records of their performances in operations, so it would not be an onerous administrative imposition to require that material

information derived from such records be made available so that it may be provided to patients for the purposes of enabling informed consent. (2004, p. 15)

Many surgeons may indeed keep detailed case notes. However, no individual surgeon's records can contain the kind of information that advocates of report cards are calling for; that is, *comparative* risk information. It is important to understand what is involved in meaningful comparative surgical audit. Comparison of surgeons' performance, with adequate risk adjustment to account for case-mix, requires all units to collect and report data against a uniform set of data standards, sufficient to apply a well-verified algorithm for assessing pre-operative risk.

To gain a sense of the kind of research necessary to provide risk-adjusted mortality comparisons for individual surgeons, consider the experience of the Society of Cardiothoracic Surgeons (SCTS) Britain. Anticipating the results of the Bristol Royal Infirmary Inquiry, the SCTS instituted the collection of data on surgeon specific activity and in-hospital mortality for several index procedures (Keogh *et al.*, 2004). The Society established a national database in 1994 which collects data on all adults undergoing cardiac surgery, beginning with 12 hospitals and now taking data from all NHS cardiac surgery units (SCTS, 2003). The main aim of the database was to develop reliable, UK-orientated risk stratification models. In the UK the process of developing an agreed minimum required dataset and standards for data reporting, and of bringing all units into a centralized data collection system was a major project, requiring national cooperation and considerable research and innovation. A study designed to assess the quality and completeness of the SCTS database was conducted by the SCTS in co-operation with the Nuffield Trust in Britain and the RAND Health Program in the United States. Sampling of the database 'revealed it to be both incomplete and unreliable in its ability to yield accurate, risk adjusted outcomes data' (Fine *et al.*, 2003, p. 28). Thus, when the SCTS published surgeon specific results, in 2004, it did so on the basis of raw, unadjusted mortality figures because it was not yet in a position to provide validated risk-adjusted mortality rates (Keogh *et al.*, 2004). Along with New York State, the SCTS in the United Kingdom has been at the forefront of surgical outcomes data collection in the world, and yet a decade of ground-breaking work is only now bringing individualised outcomes reporting within reach. The impressive work done by the SCTS in this area shows what is really involved in providing meaningful, validated, risk-adjusted, comparative outcomes data for individual surgeons. The suggestion that this kind of information could be harvested from existing records without 'onerous imposition' is rather too sanguine about the scale and analytical complexity of the task.

Once we acknowledge that determining risk-adjusted mortality rates for individual surgeons requires the kind of nationally co-ordinated database development that the SCTS has been engaged in since the early 1990s, it is

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immediately evident that it is misleading to talk about the ‘disclosure’ of such information. The obligation to disclose risk information to a patient is relative to the current state of medical knowledge. For almost any medical intervention we could name, it is likely that future research will yield information that is not currently available, but would be material to patients’ treatment decisions if it were available. There may be obligations to undertake certain kinds of research, but if research obligations exist they are not derived from disclosure obligations. Standard obligations of disclosure do not generate any obligation to produce new information that will require substantial work to discover.

Outside of those places where report cards systems are under development, the information which Clarke and Oakley want to see published would require a considerable research and infrastructure investment to produce. Resources are scarce and there is any number of potential research and infrastructure projects that could improve the understanding and treatment of disease (and by extension the quality of informed consent to such treatment). The provision of surgeon specific performance information may ultimately make an important contribution to quality and safety in surgical practice, and so it may be worthwhile to invest resources in the development of report cards. However, a demand that surgeon report cards be made publicly available is a demand that substantial resources be allocated to that end. To justify such a project, we need to show that the benefits outweigh the costs.

I am not disputing the claim that comparative information about surgeons’ performance would be valuable, both for the profession and for some patients. But no individual surgeon themselves can discover that information. Inter-surgeon comparison requires comparison of their respective case-mix in terms of a valid, standardized measure of patients’ pre-operative risk. The resource expenditure required to produce comparative tables is not mandated by the requirements of informed consent. Rather, a compelling argument for surgeon report cards needs to justify the significant opportunity costs of developing such a system.

The publication of risk adjusted mortality rates may promote transparency in healthcare, but is of quite limited value in terms of patient safety. Because a surgeon’s reputation and practice can be damaged, publicly reported outcomes data must be thoroughly validated and reliable. In New York the validation process typically means that data is 3 years old when it is published. Dated information is of limited use for informed consent. The way to deal with sub-standard surgeons is not to publish their poor results and hope that patients will choose to avoid them. What is needed is a system of continuous audit that identifies early signs of poor performance and calls surgeons and units to account well before the evidence of excessive mortality has reached the confidence level required for public reporting. In the UK the SCTS has adopted that role. It should not be via adverse publicity that a problem surgeon first comes to the attention of his or her hospital.

Clarke and Oakley briefly consider concerns that the publication of surgeon report cards will lead to defensive medicine and cite evidence suggesting that this has not happened in the case of New York. They then make the striking claim that, even if turns out that the publication of surgeon report cards does have ‘certain deleterious effects’ on the practice of medicine, their publication might still be ethically justified. They note that different ethical theories give different answers here, and while utilitarians will need to see a cost/benefit balance sheet to make up their minds, ‘some Kantians might . . . view this as a price worth paying in order to uphold respect for patient autonomy’ (2005, p. 23).

I claimed above that Clarke and Oakley’s argument violates a formal requirement on arguments based on the principle of respect for autonomy. We now turn to this second problem with the argument from informed consent. Their view that patient autonomy is enhanced by knowing the comparative, risk-adjusted mortality of available surgeons is mistaken – particularly on a Kantian conception of autonomy.

It is common to conflate autonomy with a broader and more consumerist conception of individual choice, and a version of this confusion infects Clarke and Oakley’s argument. According to Clarke and Oakley, the fact that a piece of information is material to a patient’s decision about whether or not to consent to an operation is not a sufficient condition for the patient having a right to that information. A homophobic patient might consider the surgeon’s sexual orientation material, but such information is protected by privacy rights. However they suggest that ‘it is hard to see how this sort of rationale could plausibly be applied to mount an argument for the withholding of information about a surgeon’s performance’ (2005, p. 19).

The notion of a piece of information being ‘material’ to a patient’s decision is essentially a legal concept. In the important Australian case of *Rogers v Whitaker* the High Court found that a doctor has a duty of care to disclose ‘material’ risks, and stated that a risk is material if:

In the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is, or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. (Skene and Smallwood, 2002)

Clarke and Oakley cite, with approval, the judgment in the case of *Chappel v Hart*, to make the point that they endorse a subjective conception of materiality; that is, information is material if the patient herself considers it material.

However, it is a mistake to hold that the principle of respect for autonomy always weighs in favour of giving patients information they regard as material. There are types of information that may be material to a patient’s decision, that are not protected by privacy or other rights, and yet the patient has no autonomy-based right to that information.

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The principle of autonomy is complex, but on any viable version of the principle it involves a commitment to the moral equality of individuals. The demand that others respect my autonomy implies a duty on my part to reciprocate that respect towards others. For a Kantian, an agent acts autonomously only where she intends that her actions comply with the Categorical Imperative, which means that it must be possible for all others, similarly situated, to act in the same way. For the purpose of this argument, the relevant constraint on autonomous decisions is roughly this: respect for a person's autonomy does not confer on her a right to arrogate to herself resources or limited opportunities, where by so doing those resources or opportunities are thereby denied to others. An example may help to illustrate the point.

Ms Scalpel is a surgeon whose overall performance is exceptionally good. Suppose that the majority of her work consists of one procedure, normally taking 3 hours, which she typically performs twice a day. She has kept meticulous records and has discovered that her risk-adjusted mortality rate is slightly better for the first operation of the day, in the morning, than for patients who are operated on in the afternoon. Perhaps her concentration and dexterity are diminished after several hours at the operating table. Her overall long-run mortality rate is considerably better than average, and the difference between the first and second operations of the day is slight. Suppose that, other factors being equal, her afternoon patients have a 1% higher probability of in-hospital mortality than her morning patients. Ms Scalpel knows this fact about her performance. Does she have an obligation to disclose to her patients the increased risk associated with her afternoon operations, compared with her morning operations?

No she does not. At least there is no obligation to disclose this information deriving from considerations of patient autonomy and informed consent. Any patient who knew this fact, and had the option of choosing morning or afternoon surgery, would rationally opt to be the first patient of the day. Yet the option of a morning operation cannot be given to *all* of Ms Scalpel's patients, and no patient can claim that, *on grounds of respect for autonomy*, she is entitled to a resource or an opportunity which cannot be made available to other similarly situated patients. For this reason, a patient cannot, in the name of informed consent, demand comparative performance information in order to seek out an above average surgeon or unit. The purpose of informed consent is not to help patients compete for undeserved advantage over other patients.

A patient may well want the best surgeon in the state, but a patient whose demand for the best surgeon is not met cannot thereby claim her autonomy has been violated. In general, the principle of autonomy does not require us to furnish patients with information to facilitate choices that are not universalisable. Importantly, a threshold model of publication of surgeon performance information is compatible with a Kantian view of autonomy. Threshold reporting

simply shows that a surgeon meets or fails to meet a specified performance standard. A patient can reasonably demand evidence her surgeon is safe and competent, and threshold reporting would fulfil that demand without compromising other patients.

It might be objected that providing information and providing an option are not the same thing, and that a patient may want comparative performance information for reasons other than selecting the best surgeon. A patient may simply want to know, for instance, and in such a case would not providing such information enhance autonomy? Even if we accept a subjective test for the materiality of information, such that information is material just if a patient regards it as material, it does not follow that respect for autonomy requires the development of surgeon-specific performance tables. This conception of informed consent only entitles patients to information that is both unprotected and available. Where information is unavailable and costly to produce, the mere fact that a patient would like to have that information does not generate a claim on the public dollar.

Sir Bruce Keogh, co-ordinator of the National Adult Cardiac Surgery Database in the UK (and president-elect of the SCTS) has noted that, if the purpose of publishing individual surgeon performance information is for patient choice, then the information must be presented in a comparative fashion as detailed, risk-adjusted tables. However, publishing to indicate whether a surgeon is safe or not 'requires agreeing a threshold of unacceptable mortality and then showing where each individual surgeon's results lie relative to that threshold' (Keogh *et al.*, 2004, p. 451). I have argued that considerations of informed consent, at best, support a threshold model of surgeon performance reporting. Against Clarke and Oakley, I have argued that the doctrine of informed consent in medical ethics does not require the publication of comparative performance information on surgeons of a kind that constitutes a league table.

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