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### Background

Transparency is often seen as a key to improving performance. And in response to a number of well-publicised healthcare scandals in the UK, and following public and media pressure, clinical performance data has become increasingly transparent. UK cardiac surgeons were among the first to publish their data on the internet and disclosure is now widespread. Figures 1 and 2 show examples of online surgical performance data.

But what are the actual effects of such disclosure? What strategies and tactics are employed by surgeons, hospital managers and regulatory authorities both to meet their obligations and to achieve their personal or institutional objectives?

Are the effects of disclosure overwhelmingly positive? We used the insights of Programme Theory to analyse the stages of disclosure:

identification → naming → public sanction → recipient response

and to identify the unintended outcomes arising at each stage.

### Aims

The aims of this study were:

- ❖ to examine theoretical perspectives of the disclosure of clinical performance of cardiac surgeons online; and
- ❖ to conduct an empirical study of the motives, meanings and impacts of disclosure of clinical performance data upon cardiac surgeons.

### What We Did

Our qualitative study included observation of 10 mortality meetings and 2 individual surgeons in an English NHS Trust, and 12 interviews at 3 levels of the healthcare system.

- ❖ **Individual doctors and surgical teams:** changes to autonomy and team relations
- ❖ **Organizations and hospitals:** use of data by local managers
- ❖ **National policy makers and regulators:** impact of disclosure on the regulatory regime

### Findings

#### ❖ Patient outcomes improved

Cardiac surgery mortality rates fell since the disclosure rules were introduced. We found no evidence of defensive medicine (e.g. selection of lower-risk patients) being practised, though anxiety was expressed by doctors about the impact of disclosure should their performance deteriorate. Surgeons generally accepted mortality as a performance measure (Figure 2), though some were uncomfortable with it.

#### ❖ Policy and practice perspectives differed

At the policy level we found a strong push for disclosure but at the individual doctor level, we detected a perceived threat to surgeons' autonomy and some apathy.

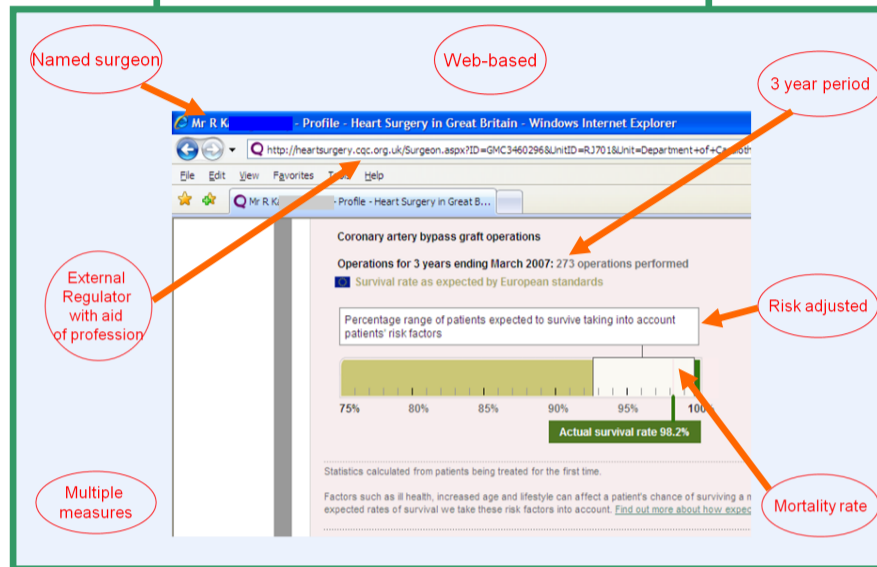
#### ❖ Disclosure was used for organizational legitimization rather than by patients

Disclosure was used by NHS Trusts to enhance surgical professionalisation and organizational reputation, but we found only limited use of the data by individual doctors and by patients.

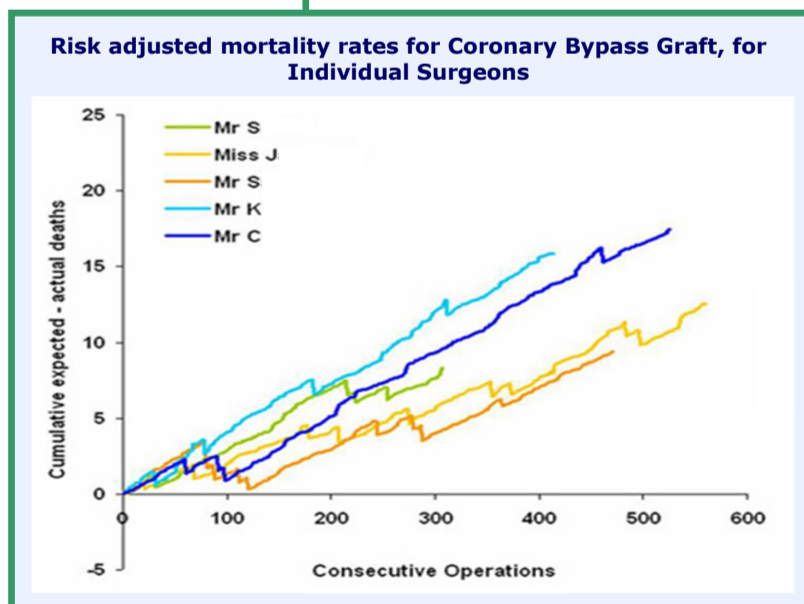
#### ❖ Disclosure had unexpected consequences

Disclosure has had an impact on surgical training, and junior doctors have accepted it as a norm to a greater extent than their senior colleagues; Stigma and reputational consequences of poor performance remain;

Disclosure is not a panacea for quality improvement.



**Figure 1**  
Example of web-based disclosure of clinical performance data (screen capture from Care Quality Commission website)



**Figure 2**  
Individual surgeons in one hospital can be compared (graphic from hospital website)

Find out more...

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