How to influence surgical practice to improve patient outcomes.

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• Board Member and Clinical Governance, Gippsland Southern Health Service
• State Committee Member of RACS and AOA
Introduction

• Not all patients have good outcomes
• Due to pathology, patients or clinicians
• How to influence practice to improve outcomes
Characteristics of Surgeons

• Skilful         Decisive        Conscientious

• Dogmatic       Intransigent    Single minded

• Slow to change
VTE prophylaxis for joint replacements

• NHMRC guidelines 2007

• Fears of bleeding, wound leakage and infection

• Vast majority of patients now have effective prophylaxis
Australian New Zealand Audit of Surgical Mortality (ANZASM)

- Review all in-hospital surgical deaths
- Peer review
- Feedback any concerns to surgeon
How does it work?

• All hospitals notify each state ASM of surgical deaths
• Treating surgeon completes Surgical Case Form
• Sent to First Line Assessor (FLA)
• 85% no further action
How does it work?

• 15% go to Second Line Assessor
• Areas of concern
• Feedback to surgeon
• Qualified Privilege
• De-identified
How did we get Orthopaedic Surgeons to participate?

• Mandatory through Continual Professional Development (CPD)

• CPD requirements are decided by The Professional Standards Committees of AOA and RACS
How do we drive change?

• Clinical advocacy
• Understand concerns
• Advocating within our professional body
How to effect change

• Education

• Guidelines

• Show that it is mainstream

• Professional bodies

• Employers and accreditors
Anything else?

- Address the concerns about increased scrutiny
- Clinician involvement
Use of Registries

- Cardio-thoracic
- Vascular Surgery Audit
- Prostate Cancer Outcomes Registry
- Breast Cancer
- Colo-rectal
AOA NJRR Background

- Data collection was introduced in 1999 commencing with SA
- National implementation was completed in 2002
- Owned by the Australian Orthopaedic Association
- Permanently funded by the Commonwealth Government
Data Collection

• 300 participating hospitals submitting data
• Voluntary and 100% participation
2016 Annual Report

• Analysis of 1,091,237 primary and revision hip – knee procedures recorded by the Registry up to 31.12.2015

• Since 2003 the increase has been 61.9% for THR and 103% for TKR
How does the Registry effect change?

• Overall usage in Australia
Resurfacing Hip Replacement
Resurfacing Hip Replacement (Primary Diagnosis OA excluding Infection)

Total Resurfacing vs Conventional Total
Entire Period: HR=1.37 (1.22, 1.55), p < 0.001
Note: Adjusted for age and gender

Cumulative Percent Revision vs Years Since Primary Procedure

National Joint Replacement Registry
Courtesy of Richard de Steiger, Deputy Director, NJRR
Yearly Cumulative Percent Revision of Primary Total Resurfacing Hip Replacement by Gender (Primary Diagnosis OA)

National Joint Replacement Registry

Courtesy of Richard de Steiger, Deputy Director, NJRR
Primary Total Resurfacing Hip Replacement by Gender

Proportion of females has declined
How does the Registry effect change?

• Individual Surgeon’s practice
Primary Hip Procedures Performed by Surgeon at Peninsula Health Service (Frankston) and Peninsula Private Hospital and Number Revised for 2008 - 2012

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Primary Procedures</th>
<th>Revisions of Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peninsula Health Service (Frankston)</td>
<td>61</td>
<td>5</td>
</tr>
<tr>
<td>Peninsula Private Hospital</td>
<td>247</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>308</td>
<td>8</td>
</tr>
</tbody>
</table>

Revision Rates of Primary Hip Replacement Performed by Surgeon at Peninsula Health Service (Frankston) and Peninsula Private Hospital by Hip Class for 2008 - 2012

<table>
<thead>
<tr>
<th>Hip Class</th>
<th>N Revised</th>
<th>N Total</th>
<th>Obs. Years</th>
<th>Revisions/100 Obs. Yrs (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unipolar Monoblock</td>
<td>3</td>
<td>34</td>
<td>115</td>
<td>2.60 (0.54, 7.61)</td>
</tr>
<tr>
<td>Unipolar Modular</td>
<td>0</td>
<td>9</td>
<td>40</td>
<td>0.00 (0.00, 9.14)</td>
</tr>
<tr>
<td>Total Conventional</td>
<td>5</td>
<td>265</td>
<td>1620</td>
<td>0.31 (0.10, 0.72)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>8</td>
<td>308</td>
<td>1776</td>
<td>0.45 (0.19, 0.89)</td>
</tr>
</tbody>
</table>
Cumulative Percent Revision of Primary Total Conventional Hip Replacement
Dr N Broughton n = 446
All other surgeons n = 372,706

HR - adjusted for age and gender
Dr N Broughton vs Other Surgeons
Entire Period: HR=0.69 (0.37, 1.27), p=0.231
Funnel Plot of Revisions of Primary Total Hip Replacement
Federal Quality Assurance Activity

- Ensures absolute confidentiality of data held by AOANJRR
- Ensures freedom from subpoena
- Prevented from releasing information that could identify a patient, surgeon or hospital
Lessons to be learnt

• Clinicians need to trust the data
• Surgeons will change their practice
• Clinicians need to look at the data
Who should be looking at individual surgeons data?

• Themselves
• With a buddy
• Professional bodies (AOA)
• AHPRA
• The public
Carnforth Station - where “Brief Encounter” was filmed
“Weak appraisal system allowed rogue surgeon to slip through the net”

Daily Telegraph
April 30, 2017
Ian Paterson - a story of failed governance

• 1996  Suspended by Good Hope Hospital then asked to leave
• 1998  Appointed to Solihull Hospital
• 2003-4  Reports documenting unsatisfactory treatment
• 2007-8  Further reports and private hospital informed
• 2012  GMC suspends registration
Notifications to Regulator

• Usually by patients and relatives

• Whistle blower problems
Improving the culture around analysis of events

• Just culture

• Fear of litigation/public shaming/restriction of practice

• Professional bodies can help here
Conclusions

• Surgeons want to improve outcomes on the basis of good data
• Benchmarking within registries
• Role of professional bodies in mentoring and educating
• Role of employers and accreditors
• Improving culture