**Public reporting of clinician-level data: views of senior medical administrators in Victoria,
Australia**

(Up to 15 word introline): The case of public disclosure of individual doctors' performance
to increase hospital quality and safety

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Abstract *(100 words, not for publication, for correspondence with reviewers)*

Among a group of public hospital Chief Medical Officers (CMOs) and Directors of Medical Services (DMSs) in Victoria, Australia, we found an unexpected level of in-principle support for public reporting of individual clinician-level data as a means to improve healthcare quality, increase transparency, and inform consumer healthcare decision-making. This paper outlines their arguments for and against such reporting, making clear their perspectives and concerns and situating them alongside international literature. Public reporting of individual clinician-level information is an area worthy of research and debate given its potency and relevance against a backdrop of striving for improved hospital quality and safety.

Public reporting of clinician-level data: views of senior medical administrators in Victoria, Australia

The case of public disclosure of individual doctors' performance to increase hospital quality and safety

In 2016, public reporting of a cluster of potentially avoidable deaths of babies born at a Victorian health service (Australia), and the subsequent review of hospital safety and quality assurance in Victoria (see *Targeting Zero*, the report of the review¹), increased the prominence of public reporting of hospital performance data. In *Targeting Zero*, it is suggested that the health system must develop a culture of candour with improved transparency at every level of the hospital system—"achieved through greater public reporting of outcomes data and support for a just culture in hospitals".¹

There is evidence to support that public reporting of hospital performance data, which can include individual clinician-level data, can have positive impact on quality improvement at the hospital-level;²⁻⁴ its impact on consumer decision-making is less clear.^{5,6} Public performance reporting, whether at organisational, clinical unit or individual clinician-level, is widely considered a means to improve transparency and accountability, and a mechanism to drive quality improvement and inform healthcare decision-making.^{3,7,8} It is an expanding phenomenon in Australia and elsewhere,^{5,8} described as "exploding" in the USA where there are reportedly over 4000 public reporting sites with more in development.⁹

In 2011 the Australian government introduced *MyHospitals*, a web-based portal to provide nationally consistent and comparable performance information about public and private hospitals. Currently just seven of 17 indicators are reported on due to

methodological challenges and lack of data—all at hospital level. Reporting to *MyHospitals* is mandatory for public hospitals but voluntary for private sector providers.

Unlike Australia, public reporting in the UK includes ratings of the outcomes of individual hospital specialists.⁵ In the USA there is also some identifiable reporting on individual clinicians—although it is mostly voluntary; a well-known example is the public reporting of cardiac surgery performance.¹⁰ Public reporting to individual clinician-level is controversial due to the methodological issues related to risk adjustment and potential for unintended negative consequences.^{5,11,12}

We conducted interviews to improve understanding of how public reporting of hospital performance data impacts quality of care with a group which including medical directors from 27 Victorian hospitals (see Box 1). Public reporting of individual clinician-level data was a key issues raised by several Chief Medical Officer (CMO) and Director of Medical Service (DMS) informants. Despite the controversy around reporting clinician-level data there was strong in-principle support from CMOs/DMSs (12/15) providing that certain caveats were addressed. Their support was not for a particular model of clinician-level reporting, as is discussed below. The perspectives of the CMOs/DMSs below highlight the considerations that need to be taken into account during debate on whether public reporting should be undertaken at the individual clinician level.

Box 1.

Research outline

Aim: To gather insights into the underlying mechanisms through which public reporting of hospital performance data affects institutional behavioural change towards quality improvement.

Design: An exploratory, non-generalisable study based on thematic analysis of anonymous semi-structured interview data with CMO/DMS members of an associated medical directors group. One

component of a larger research project.

Informants: 17 Chief Medical Officers or Directors of Medical Services, representatives of 26* major (metropolitan & regional), subregional, local-rural, and small-rural hospitals.

Refusals: Of the 25 CMOs/DMSs invited (2 speciality hospitals were excluded), 4 refused and 4 positions were vacant/newly filled.

Data collection: Face-to-face and telephone interviews averaged 49 minutes (range: 30 to 69 minutes), undertaken between June and August 2016. One interview per informant.

Bias: Potential sample bias due to their membership of an associated group.

Ethics approval: Granted by (withheld for review).

Significance: The opinions of CMOs/DMSs about public reporting had not been previously canvassed in Australia.

* There are 86 health services in Victoria. Some participants were CMO/DMS for multiple regional health services.

CMO = Chief Medical Officer; DMS = Director of Medical Services

Support for and against clinician-level public reporting

“I know the reticence of a lot of my colleagues and I think if you actually want to get to the bare bones of: ‘What type of data will drive change?’; individual clinician-level data is the winner by a mile.” (CMO informant quote)

At the core of the arguments made by CMOs/DMSs for public reporting of individual clinician-level data is the public’s right to a fully transparent and accountable healthcare system. This philosophical position is part of a trend towards greater transparency and broader disclosure of adverse outcomes. More pragmatically, it was considered highly useful information for consumers and referring doctors to guide decision-making, and as a way to prevent poorly performing clinicians from hiding in an otherwise above average work

unit. It was considered a mechanism to prompt poor performers to improve or stop practising, and a means to do away with any delusion that clinicians might have about their performance. Such identifiable disclosure was considered by some CMOs/DMSs to be *the* most effective way to motivate all clinicians to either change their own behaviour or to change the system in situations where the system was at fault. Reticence to publicly share such information was suggested to be a red flag indicating that the organisation or clinician had something to hide. Differences between the public and private sectors were raised, highlighting that such data would be unlikely to influence decisions by patients in the public sector (but it would be useful in the private sector where healthcare consumers can exercise greater choice).

Underpinning arguments against reporting individual clinician-level data is the idea that making public such information erodes trust between clinicians and their employers/the healthcare system. The potential for public publication of clinician-level data to destroy the career of a good clinician, drive clinicians to avoid taking on patients likely to have poor outcomes, push more complex cases to the public sector, and undermine trust between physicians and their employers—leading to disengagement of clinicians and erosion rather than improvement of quality—were reasons given by the CMOs/DMSs why it should not occur. These arguments echo those made and analysed elsewhere.¹² In the UK, negative consequences of clinician and hospital rating systems have been associated with reduced staff morale, erosion of public trust, the deliberate manipulation of data, altered behaviours to obtain strategic advantage (gaming), bullying to maintain star ratings, and incorrect inferences being made about performance data.¹¹ There was concern among CMOs/DMSs that individual clinician-level data would not likely account for the influence of the different professional teams that doctors work in, and that different teams can lead to different

results for an individual specialist. Lack of robust and reliable data was another argument against, but for most CMOs/DMSs this was a caveat why it should not occur now rather than why it should not occur at all.

While in-principle support was strong, caveats and qualifiers related to issues around: methodology and data collection; legality related to informed consent from clinicians and privacy rights for patients and clinicians; ensuring adequate narrative to make the data meaningful; and the need to first improve public understanding of the data (health literacy). There was concern that data and administrative mechanisms are currently unable to provide appropriate, meaningful, quality data that is suitably risk adjusted to capture that some clinicians take on most of the ‘hard’ cases. If reported, individual-level data needs to somehow acknowledge that poor outcomes do not necessarily mean a poorly performing clinician.

How and what to report?

‘With care and caution’ was how CMOs/DMSs thought individual clinician-level data should be publicly reported. The need for accompanying narrative, about the data and about clinicians, was strongly urged—without which there could be no hope of clinician-level data being meaningful to the public. The difference between *data* and *information* was raised with *information* considered more useful for consumers. To maintain trust between clinicians and their employers it was suggested that information be given “in a non-blame and shame way” and could include doctors’ experience, training and scope of practice. At odds with this was a suggestion that clinician-level reporting should not go beyond basic tick or cross responses related to competencies, with more detailed clinician-level data not available to the general public. The need to reduce the risk of information being sensationalised or made the focus of negative media scrutiny was a thorny issue without

well-developed solutions. Several CMOs/DMSs suggested communicating positive stories, such as individual success stories, to learn from and build trust within and around health systems.

Where to next?

Informants had very differing conceptions of what public reporting of individual clinician-level data might 'look like' which may in part explain difference in levels of support. For example, one CMO/DMS who supported clinician-level reporting envisaged its execution in a way more limited than another who was opposed but who described making public a detailed range of identifiable information. This highlights the need to lay foundations for debate through clarification of what might be within the scope of public reporting of individual clinician-level 'data' versus clinician-level 'information'. It might be that some opposing positions are closer than they first appear.

While the ethical obligation of disclosing clinician-level data/information was not raised by our informants, it is explored elsewhere.^{10,13,14} In theory, information about an individual clinician's performance is as relevant to informed choice as some of the rare clinical risks that are routinely discussed with patients.^{10,13,14}

There has been very little information drawn from senior hospital executives on their perspectives of the impacts and potential consequences of public reporting of hospital-level, let alone clinician-level performance data.¹⁵ While the perspectives outlined here are limited to the public healthcare sector in Victoria and are not generalizable, they indicate that there could be more support among senior medical administrators for clinician-level public reporting than might first be assumed. If public reporting of clinician-level data ever becomes a reality in Australia, then the experiences of other countries should be carefully considered with particular attention to lessons learned.^{11,16} Overall, this is an area worthy of

more research and debate given the potency of the issues and their relevance to improving hospital quality and safety in the ever expanding local and global arenas of public performance reporting in healthcare.

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Declarations

Competing interests

No relevant disclosures.

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