Viewpoint

Surgeons, high risk interventions and the birth of the Star Chamber

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In the past, surgeons and doctors carried out their work with little measurement of their clinical outcomes and with no external scrutiny of such outcomes. This era is now finished. In the last century, medicine has progressed from haphazard treatments given with little scientific grounding to rigorous evidence-based treatment. In the last twenty years, we have seen a new development: the evaluation and monitoring of how well such treatment is administered or, in other words, the quality of the delivery of medical care.

Cardiac surgery has led this field, largely because it is, as a specialty, a relatively easy one to monitor and evaluate: most of the operations carried out within it belong to three or four subgroups (coronary, valve, combined etc.) and the specialty has long ago measured its outcomes, if only in using the relatively crude outcome of survival. It had to, to justify its aggressive approach in its early days against the 'safer' but more ineffective medical treatments available for heart disease. Another reason for cardiac surgery's dominant position in the field of care quality monitoring is a less salubrious one: the scandals that have erupted when care was substandard, such as the Bristol affair (1).

Whatever the reasons, cardiac surgery is now scrutinised like no other specialty in history. Some of this scrutiny comes in the form of peer-reviewed outcomes and clinical governance, but much of it is in the form of open publication of results in the public domain. In the United Kingdom, this is now done by institution and by individual named surgeon (www.scts.org) and the outcomes are there for all to see. Similar ventures occur in the United States and elsewhere, and the clamorous demand for more transparency is likely to force such publication of outcomes throughout Europe and the rest of the world in the near and mid-term future.

Generally, transparency is a good thing. However, it has led to some evidence of 'gaming' the figures (2) and there are instances where it can lead to harm both for patients and for surgeons. There is a possibility that anxiety about their published figures may discourage surgeons from taking on high-risk patients. This is especially damaging as it is often, paradoxically, these very patients who stand to gain most from cardiac surgical intervention as, without such intervention, their outlook is very bleak indeed. In one survey (3) of cardiac surgeons in the United Kingdom, we found that over a third of surgeons admitted to turning down high-risk patients for surgery because they were concerned about the impact this might have on their published outcomes despite the fact that they believed that surgical intervention was in the best interests of the patient.

Transparency is here to stay. Once we have started to publish outcomes, it is very difficult to stop doing so. At the very least, it would look highly suspicious to the public to stop providing information that was hitherto freely available. We should, however, take steps to mitigate the damaging effects of transparency on our patients and on us surgeons and one possible approach is the development of star chambers.

The proper name for the Star Chamber is 'Surgical Council', but it seems that the more popular name has secured common usage in the profession. The Star Chamber functions in a simple way: surgeons are advised to bring to the attention of the chamber any patient who is considered to be at exceptionally high risk from cardiac surgery. At Papworth Hospital, this includes:

- Patients turned down for treatment at other hospitals because of perceived risk;
- Patients referred for transplantation in whom conventional surgery is being contemplated as an alternative;
- Patients with a logistic EuroSCORE (4) of 25% or

above (equivalent to a EuroSCORE II (5) of 12–15% or above);

- Patients who do not satisfy the above criteria but who the surgeon feels carry an exceptional risk due rare risk factors or unusual combinations of risk factors.

Once a patient is referred to the Chamber, the case is presented at a regular fortnightly meeting attended by a minimum of four consultant surgeons for the Chamber to be considered quorate. After the case presentation, a discussion ensues to determine the following:

- Whether the patient should be offered an operation and, if so;
- What the nature of the operation is and the strategy and approach to be adopted;
- Which of the consultants will perform the procedure on behalf of the Chamber (minimum 2 consultants).

The patient is then offered the operation and, if willing, is admitted under the care of the group. The operation is carried out by the consultants chosen in the name of the entire group. One consultant is nominated as the line of first call for postoperative care but the entire group of surgeons takes corporate responsibility for the outcome. Within Papworth Hospital, operations carried out in this way are subject to the same data collection, quality monitoring and local and national data publication as are all other operations.

The advantages of such an approach are legion. Any reluctance to take on high-risk patients will be reduced. The effect of any overloading of an individual surgeon with high-risk cases will be neutralised. Most importantly, the highest risk patients gain the benefit of the pooled wisdom and expertise of a highly experienced and specialised group of cardiac surgeons who, amongst themselves, choose the best team for the job of performing the actual surgery. This has the potential of further improving the results of the highest risk cardiac operations.

By the end of 2017, 127 patients have been referred to the Star Chamber at Papworth. More than half have been operated with good results overall. The results have tended to be best in patients turned down in other centres and less good in patients referred from within the Papworth surgical practice. This is not surprising since, as a general rule, Papworth tends to be less risk-averse than other units in the United Kingdom so that patients referred from Papworth to the Star Chamber are often those with an exceptionally parlous risk profile.

The Star Chamber has succeeded in ensuring that high-risk patients who otherwise could have been denied heart surgery because of the impact of the transparency culture will now receive the opportunity of surgical care when it is in their best interests. Other units in the United Kingdom are also contemplating similar initiatives.

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Footnote

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