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Artículos especiales

Assessing quality in cardiac surgery

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Evaluando la calidad en cirugía cardíaca

Existe una fuerte relación temporal, si no causal, entre la intervención y los resultados en cirugía cardíaca, y, por lo tanto, se establece una relación entre la mortalidad operatoria y la medición de la capacidad y resultados quirúrgicos. En el Reino Unido, la ley estipula que los resultados obtenidos en cualquier institución pública o utilizando fondos públicos deben ser hechos públicos y disponibles en cualquier momento. Las herramientas y mecanismos que diseñamos y desarrollamos es posible que lleguen a formar parte de los modelos con los que se evalúa la calidad del cuidado médico en otras especialidades médicas y quirúrgicas. La medición de la capacidad profesional debe ser hecha en la misma profesión. Para medir el riesgo existe un número de sistemas de puntuación, ya que la mortalidad cruda no es suficiente. Un beneficio muy importante de la evaluación del riesgo de muerte es utilizar este conocimiento para determinar la indicación para una intervención. El segundo beneficio reside en la evaluación de la calidad del cuidado médico, ya que la predicción del riesgo proporciona un punto de comparación frente a los resultados de los hospitales y de los cirujanos. La revisión por pares y el «nombrar y criticar» son dos mecanismos para la monitorización de la calidad. Existen dos resultados potencialmente peligrosos de la publicación de resultados en forma de tabla de clasificación liguera: el primero es el daño al hospital; el segundo es el rechazo a operar a pacientes de riesgo elevado. Existe una necesidad real de monitorizar la calidad en la medicina en general y en la cirugía

There is a the strong temporal, if not causal, link between the intervention and the outcome in cardiac surgery and therefore a link becomes established between operative mortality and the measurement of surgical performance. In Britain the law stipulates that data collected by any public body or using public funds must be made freely available. Tools and mechanisms we devise and develop are likely to form the models on which the quality of care is assessed in other surgical and perhaps medical specialties. Measuring professional performance should be done by the profession. To measure risk there are a number of scores as crude mortality is not enough. A very important benefit of assessing the risk of death is to use this knowledge in the determination of the indication to operate. The second benefit is in the assessment of the quality of care as risk prediction gives a standard against performance of hospitals and surgeons. Peer review and "naming and shaming" are two mechanisms to monitor quality. There are two potentially damaging outcomes from the publication of results in a league-table form: the first is the damage to the hospital; the second is to refuse to operate on high-risk patients. There is a real need for quality monitoring in medicine in general and in cardiac surgery in particular. Good quality surgical work requires robust knowledge of three crucial variables: activity, risk prediction and performance. In Europe, the three major specialist societies have agreed to establish the European Cardiovascular and Thoracic Surgery Institute of Accreditation (ECTSIA). Performance monitoring is soon to

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cardíaca en particular. El trabajo quirúrgico de calidad requiere un conocimiento profundo de tres variables cruciales: actividad, predicción del riesgo y resultados. En Europa, las tres principales sociedades de especialidad han acordado establecer el Instituto Europeo de Acreditación en Cirugía Torácica y Cardiovascular (ECTSIA). La monitorización de los resultados será pronto imperativa. Si los cirujanos no estamos a bordo, acabaremos por no tener el control sobre su destino final, y las consecuencias pueden ser igualmente dañinas para nosotros y para nuestros pacientes.

Palabras clave: **Evaluación de la calidad. Cirugía cardíaca. Estratificación del riesgo. Monitorización de la calidad.**

become imperative. If we surgeons are not on board, we shall have no control on its final destination, and the consequences may be equally damaging to us and to our patients.

Key words: **Quality assessment. Cardiac Surgery. Risk stratification. Quality monitoring.**

Usually, doctors do their best for their patients. For physicians, if medical treatment fails and the patient dies, we blame the disease, not the treatment or the doctor. It is different for surgeons. This is not surprising because of the strong temporal, if not causal, link between the intervention and the outcome. As cardiac surgery began to stake its rightful claim in the field of treatment of heart disease, surgeons had to justify their aggressive and high profile intervention by showing that they could achieve cure or palliation for the majority with an "acceptable" risk of death for the minority. It was inevitable that a link would become established between operative mortality and the measurement of surgical performance.

In January 2005, the "Freedom of Information" Act became law in Britain. It stipulated is that data collected by any public body or using public funds must be made freely available, to anyone who asks, within 20 days. Data collected by cardiac surgical audit departments fall within this group, as they are gathered using National Health Service resources. Within days of the act becoming law, *The Guardian* national newspaper contacted all cardiac surgical units in the country and requested the mortality figures for all cardiac surgeons, by name, for isolated coronary surgery and aortic valve replacement over the past 3 years. Units complied (they had no choice) and submitted the data: some did so willingly, some under protest and many were worried about how the newspaper will present the data. Some units (Papworth included) submitted risk-stratified data with 95% confidence limits and statistical analyses. Some submitted crude risk stratification (low and high risk). Others submitted crude data. *The Guardian* treated the data very responsibly: they published in alphabetical order (not in order of mortality), explained risk stratification and, where available, published risk data and confidence limits[1]. This was exceptional: whenever other newspapers dealt with these issues in the past, they tended to sensationalise the reports with headlines like "the worst hospital in Britain" and statements like "scores of patients are dying needlessly…" appearing out of reports of unreliable, unadjusted crude data.

Freedom of information is a growing trend. Cardiac surgical outcome data will not be confidential for long. When that happens in your part of the world, will your newspapers be responsible like *The Guardian* or sensationalist like the others? My bet is that it will be the latter.

Measuring professional performance should be done by the profession, before the newspapers do it for us. We are on the threshold of a brave new world in which the measurement of cardiac surgical performance will no longer be peripheral to our work, but an integral part of it: as important as the indication for surgery, the choice of procedure, the skill with which it is performed and the postoperative care. Moreover, the tools and mechanisms we devise and develop are likely to form the models on which the quality of care is assessed in other surgical and perhaps medical specialties.

DOES OPERATIVE MORTALITY MATTER?

Governments and health authorities care much about cost and possibly not enough about clinical outcomes. Surgeons and their patients care more about outcomes (and possibly not enough about cost). Sometime in the late 1980s, a health authority paid a large sum of money to a famous firm of accountants and management consultants to examine the performance of the two cardiac surgical centres in its area. After a

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