The use of public reporting for quality initiative metrics for cardiac surgery is now commonplace throughout the United States and internationally. This is especially true for the most commonly performed adult cardiac surgical procedures, coronary artery bypass grafting (CABG), and aortic valve surgery (AVR). In 1989, the Society of Thoracic Surgeons (STS) developed an Adult Cardiac Surgery Database (ACSD), which is a clinical data registry promoting quality improvement in cardiac surgical outcomes. Baseline and intraoperative patient characteristics and operative outcomes are collected using standard definitions, with routine data auditing that has shown >95% accuracy versus chart abstraction. More than 90% of the ≈1100 US cardiac surgery programs participate in the registry. Throughout the years, surgeons have used this database for quality improvement and research initiatives, many of which have changed the contemporary practice in cardiac surgery. Each participating program gets an institutional risk-adjusted report card for process improvement. More recently, each surgical program is given a star rating (1–3) based on measures of quality used by the STS in the ratings for CABG. This National Quality Forum-endorsed rating system allows programs to compare themselves with other hospital programs performing CABG. Although this process had many initial critics, the public reporting of outcomes in those undergoing cardiac surgery attests to the goal for transparency and physician and hospital reimbursement based on the quality of the surgical intervention. In concert, the New York State Department of Health developed a registry to collect clinical data on all patients undergoing CABG in the state of New York. Similarly, Pennsylvania was 1 of the earlier states to provide report cards for cardiac surgeons performing CABG. However, in that state as in New York, Dr Epstein has failed to detect a significant change in referral patterns to either low- or high-mortality surgeons.

There is no question that accountability for outcomes is desired not only by cardiac surgeons but also by patients, healthcare institutions, and insurance carriers. Whether public reporting drives these processes in a positive manner is still to be determined. In the current eloquent study by Brown et al, the authors have noted that, despite 20 years of public reporting in New York, cardiologists made little use of adjusted outcomes and rarely discussed it with patients at the time of referral. Drs Brown and Epstein are on the forefront of this specific topic with considerable knowledge on public reporting for cardiac surgery. It is surprising to us that although 94% of cardiologists were aware of public reporting, 25% actually allowed this to be a moderate or substantial influence for referral patterns. Moreover, 57% did not think that the data were important and 71% did not discuss the adjusted outcomes with their patients at the time of referral. Interestingly, board-certified cardiologists were less influenced by the reporting, whereas general cardiologists were more likely to find the data impactful. As is inherent with any questionnaire analysis, the authors only sampled a small percentage of cardiologists (23%), of which some had not referred a patient for cardiac surgery in the current year (Table 1). It is difficult to tell from the current study whether a cardiologist in a metropolitan versus rural geographic area was a factor in referral patterns. For instance, in a rural setting, if a cardiologist had to choose to send the patient to a center 60 miles away, would he choose to send that patient to the local program versus not? Of concern is the cardiologist’s disbelief in the validity of the public reporting, despite the use of risk-adjustment methods to evaluate the surgeon. This is apparent in the current study with 93% of cardiologists referring to >1 surgeon and 75% to >1 hospital. It seems that cardiologists make the decision for referral based on their personal experience with the surgeon or hospital system.

We do think that the authors have made some important findings, which show that despite public reporting, cardiologists consider more subjective aspects such as patient satisfaction and historical surgeon relationships or perceived technical prowess in referral decisions. This seems to be a consistent finding in this and previous studies with a general skepticism on the validity of the report cards as used in their current state. We share in the disappointment of the authors that discussion of these reports is not made with the patients. This may, in part, be secondary to a growing number of hospital system-wide alliances that are highly suggestive to practicing cardiologists for referral pattern. It is plausible that further research is necessary to find a more representative criterion that will better take into account the variable referral patterns of cardiologists for patients undergoing cardiac surgery.

Disclosures
None.

The opinions expressed in this article are not necessarily those of the editors or of the American Heart Association.

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