



**Clinician-level Quality Indicator Reports:
A qualitative research project
to understand the views of clinicians
receiving and not receiving these reports**

FINAL REPORT

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**Maggie Kirkman and Jane Fisher
Monash University**

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PROJECT TEAM

Dr Maggie Kirkman	School of Public Health & Preventive Medicine, Monash University
Professor Sue Evans	Victorian Cancer Council
Professor Peter Heathcote	Brisbane Urology Clinic; Australian Prostate Cancer Research Centre, Queensland
Professor Jane Fisher	School of Public Health & Preventive Medicine, Monash University
Professor Jeremy Millar	Central Clinical School, Monash University; Radiation Oncology, Alfred Health
Mr Stephen Mark	Christchurch Hospital, New Zealand
Professor David Currow	Cancer Institute, New South Wales
Professor Mark Frydenberg	Department of Surgery, Faculty of Medicine, Nursing & Health Sciences, Monash University; Cabrini Institute, Cabrini Health
Professor Mohamed Khadra	School of Medicine, University of Sydney; Nepean Blue Mountains Local Hospital District

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ABBREVIATIONS

ABBREVIATION	TERM
PCOR-ANZ	Prostate Cancer Outcomes Registry, Australia and New Zealand
PCOR-Vic	Prostate Cancer Outcomes Registry, Victoria
PROMS	Patient Reported Outcome Measures
SAG	Special Advisory Group
SET	Surgical Education and Training
USANZ	Urological Society of Australia and New Zealand

SUMMARY

The aim of this research was for the Australia and New Zealand Prostate Cancer Outcomes Registry (PCOR-ANZ) to reach a better understanding of urologists' responses to Quality Indicator Reports and of the best way to manage clinicians who fall more than two standard deviations below the mean. Management might include a mentoring program. It was also sought to identify any differences in opinions about the report and mentorship that arise from where urologists work and whether they have previously received reports. **The objectives** were to enhance the registry's ability to interact with clinicians and to improve patient outcomes.

Medical specialists were eligible for inclusion if they were members of the Urology Society of Australia and New Zealand (USANZ) and treating men with prostate cancer in Australia or New Zealand. Members are predominantly urologists but also include other specialities such as radiation oncology. It was hoped to recruit members who did and did not contribute to PCOR-ANZ. In addition, we sought to recruit members who did and did not receive a quality indicator report produced by PCOR-ANZ. To ensure diverse perspectives, we targeted members with varied urological experience, sex/gender, country of birth, and rural/metropolitan practice, as well as from at least four jurisdictions: Victoria, New South Wales, Queensland, and New Zealand.

A qualitative method (semi-structured interviews) was selected as appropriate to seeking personal perspectives on a topic. In qualitative research, the goal is not to compare different groups but to represent a wide range of perspectives. It was expected that a maximum of 20 participants would provide sufficient data to address the research objective. Transcripts of interviews were analysed thematically.

Recruitment was limited by COVID-19 and its associated restrictions. We were told this directly and indirectly by many specialists we approached. This caused a delay in finalising the project.

Nevertheless, **12 specialists were interviewed**. Most practised in Australia (5 Victoria, 4 Queensland); the remaining three practised in New Zealand. We were unable to attract volunteers from New South Wales. They worked across metropolitan, regional, and rural areas, and had been practising for 5-30 years (mean 18 years). We were unsuccessful in recruiting women, who were among those who cited the challenges of living with the concomitants of SARS-CoV-2.

Results are categorised in the themes Prostate Cancer Outcome Registry, Quality Indicator Reports, Action on Receiving Reports, Meaning of Scores, Outliers, Helping Outliers, USANZ's Role, Mentor Scheme, and Improving Reports. Diverse views were expressed in relation to all themes.

Prostate Cancer Outcome Registry: Eleven participants contributed to the registry, which was identified by all 12 participants as being fundamental to improvements in standards of care and of practice. It was suggested that concerns about centralising care might deter some clinicians from contributing.

Quality Indicator Reports: Reports were assessed as valuable because they contribute to improving patient care and have the potential to improve clinicians' skills. Some participants wanted to disallow the use of high-scoring reports for advertising.

Action on Receiving Reports: Ideally, clinicians would use reports to reflect on their practice and improve it where necessary. Beneficial usage of reports was linked to a collegial atmosphere. There was concern that automatic sharing of reports could lead to public shaming. It was thought that reports could evoke a defensive response in outlier clinicians who might then not benefit from them. Possible differences in health care delivery between Australia (more individual surgeon/private) and New Zealand (more public and within a group) were suggested as influencing action on reports.

Meaning of Scores: Whether scores were high or low, it was seen as important to distinguish factors reflecting practitioner competence from those beyond their control, such as case selection. Outliers were recognised as a problem requiring a solution. It was noted that, overall, quality has steadily improved since the register was established.

Outliers: It was recommended that outliers should reflect on the results, seek advice, and take steps to improve. It might be advisable for the clinician to cease performing some procedures. There were no feasible suggestions for a replacement term for 'outlier'.

Helping Outliers: There were diverse opinions on how best to assist clinicians to improve, with a majority view that approaches should not be punitive. A punitive approach risks having clinicians refuse to contribute data. It was felt that not all outliers would be prepared to be helped. The head of department should be aware of scores and has an ethical or moral obligation to take steps to manage an outlier in the most appropriate way.

USANZ's Role: There were differences of opinion on whether USANZ had a role in managing outliers. USANZ was urged to take a strong role by some participants but advised to stay well away from intervention by others. One suggestion was that the PCOR could offer advice to outliers without breaching confidentiality by sharing identified data with USANZ.

Mentor Scheme: Although a mentor scheme was generally endorsed, serious concerns were raised about how it might work in practice and whether those who needed it most would choose to participate. Any scheme would require skilled and experienced mentors, high ethical standards, and strict confidentiality. It was suggested that a mentorship scheme could be available to anyone who wants it, not just to outliers.

Improving Reports: Suggested improvements included adding data such as whether procedures were performed by a registrar in training and more details of patient characteristics. Some liked the new way of presenting data whereas others preferred the old way. Rationalisation of fields and frequent reassessment of the algorithm were recommended. There was a request to make PROMS packs available in languages other than English and for those with limited literacy.

EXTENDED SUMMARY OF RESULTS

PROSTATE CANCER OUTCOMES REGISTRY

- Ten participants contributed to the registry; one said that his data had been contributed by someone other than him.
- The PCOR was welcomed by all 12 participants.
- It was identified as being fundamental to improvements in standards of care and of practice.
- There is an identified need to ensure that data are not used to move patients from small centres to cities, and to reassure clinicians outside the cities that this is the case. It was suggested that concerns about centralising care had led to the refusal of one centre to contribute data.
- There was some concern that poorly-performing surgeons might be less likely to contribute data.
- It was suggested that data should distinguish watchful waiting from active surveillance.

QUALITY INDICATOR REPORTS

- Reports were assessed as valuable because they contribute to improving patient care and have the potential to improve clinicians' skills.
- Reports were valued as an objective assessment of a clinician's work.
- Clinicians sometimes use their own reports in conversations with patients to illustrate a good track record.
- Some expressed concern that high-scoring reports might be used in advertising; this was considered to be regrettable.

ACTION ON RECEIVING REPORTS

- Ideally, clinicians would use reports to reflect on their practice and improve it where necessary.
- Beneficial usage of reports was linked to a collegial atmosphere. Places that lacked collegiality or where clinicians worked in isolation were seen to make it less likely that reports would be acted on appropriately. However, there was also concern that automatic sharing of reports, whether to peers or administrators, could lead to public shaming.
- Although most respondents reported discussing reports with colleagues and using them to improve practice, it was thought that reports could evoke a defensive response in clinicians whose position on the distribution was not as favourable as they expected.
- It was suggested that some clinicians whose reports positioned them at the wrong end of the distribution would be reluctant to discuss them with anyone, thus making it difficult to use them to improve practice.
- Differences in health care delivery between Australia, with an emphasis on individual surgeons and private practice, and New Zealand, with an emphasis on group practice in public hospitals, were suggested as influencing action on reports.

MEANING OF SCORES

- Whether scores were high or low, it was seen as important to distinguish factors reflecting practitioner competence from those beyond their control, such as case selection.

- Scores might reflect procedures performed by a trainee surgeon that were registered for the supervising clinician, to the latter's detriment.
- The lack of pre-operative data was identified as a potentially mitigating factor in assessing outcomes.
- It was noted that, overall, quality has steadily improved since the register was established.
- Nevertheless, outliers—those with poor scores—were recognised as a problem requiring a solution.
- Restricting the procedures that could be performed by an outlier clinician was proposed as a matter requiring serious consideration.

OUTLIERS

- Recommendations for clinicians who found themselves to be outliers reflected those for the ideal response to the reports: Reflect on the results, seek advice, and take steps to improve, such as by seeking further training.
- One step to be considered is whether the clinician should cease performing certain procedures.
- There were no feasible suggestions for a replacement term for 'outlier'.

HELPING OUTLIERS

- Data should be used to contribute to improvement.
- It was felt that not all outliers would be prepared to be helped and that arranging courses would not be straightforward.
- Any assistance needs to be tailored to the individual.
- It was emphasised that attempts to assist clinicians to improve should not be punitive. A punitive approach risks having clinicians refuse to contribute data.
- However, it was said that the head of department should be aware of scores and has a moral or ethical obligation to take steps to manage an outlier in the most appropriate way.

USANZ'S ROLE

- There were differences of opinion on whether USANZ had a role in managing outliers.
- On the one hand, USANZ was urged to take a strong role; this approach was identified as both brave and the most desirable from the perspective of the general public.
- On the other hand, USANZ was urged to stay well away from intervention, instead encouraging the PCOR to offer advice to outliers.
- One reason given for PCOR taking responsibility was the ethical and possibly legal concern about breaching confidentiality by sharing identified data with USANZ.
- One suggestion was that a Special Advisory Group could take that role, although potential problems were identified in the perception of unwanted surveillance.

MENTOR SCHEME

- Although a mentor scheme was generally endorsed, serious concerns were raised about how it might work in practice and whether those who needed it most would choose to participate.
- Mentors need to be highly skilled and experienced, but they might be difficult to recruit and reluctant to take the responsibility of certifying a surgeon as meeting the required standard.

- The scheme must endorse high ethical standards and maintain confidentiality.
- A majority said that outliers should initiate contact once they had been given a list of potential mentors. Another view was that mentors should be allocated.
- It may be necessary to follow up clinicians who fail to contact a mentor once mentorship has been recommended.
- It was suggested that a mentorship scheme should be available to anyone who wants it, not just those identified as outliers.

IMPROVING REPORTS

- Improvements were suggested based predominantly on personal experience.
- Some liked the new way of presenting data whereas others preferred the old way.
- Data that could usefully be included were named as whether a registrar did a large fraction of the operation for training, information about ethnic origin or country of birth, and other patient characteristics such as impairments and BMI.
- Rationalisation of fields was recommended.
- Frequent reassessment of the algorithm was recommended to ensure continuous improvement.
- It was recommended that the PROMS packs should be available in languages read by patients and should also cater for those with poor literacy.

BACKGROUND

The Australia and New Zealand Prostate Cancer Outcome Registry (PCOR-ANZ) was established in 2014 as a clinical quality registry to monitor the quality of care provided to patients with prostate cancer by hospitals and clinicians contributing to the registry (Evans et al., 2016). Indicators of quality of care were developed through an international consensus process. These quality indicators are used to assess the performance of hospitals and clinicians, who receive a Quality Indicator Report summarising the patterns of care of patients they are managing and comparing their individual performance with the population mean (Nag et al., 2018).

The Victoria Prostate Cancer Outcome Registry (PCOR-Vic) predated the PCOR-ANZ, beginning the six-monthly distribution of Quality Indicator Reports to contributing hospitals and clinicians in 2012 (Rao et al., 2014). From 2018, the reports developed by PCOR-Vic were expanded to become national and cross-Tasman, with each hospital's and clinician's performance against QIs displayed in a single report.

There is suggestive evidence from a 2017 Monash University Honours student project that Quality Indicator reports are generally well received (Unpublished thesis by Harvey Koh). The 10 urologists who were interviewed said, for example, that "the format is excellent and it serves an excellent purpose", "I find it extremely useful", and "it's a fantastic way to benchmark yourself against your colleagues and against the state average for various indicators". However, there were also concerns about the validity of the data, the possibility of a reputational risk if data were misrepresented, and that the performance measures could not take account of patient and health service factors beyond clinicians' control. A suggested reason for below-average performance was, "seeing more advanced disease because they present later". Concern about the inevitability of some clinicians being below average was that "it could be used to vilify certain individuals".

The PCOR-Vic and the PCOR-ANZ Steering Committees are considering how best to manage clinicians who fall below the 'normal' range (defined as two standard deviations below the mean). The goal is to be sensitive and responsible to both clinicians and their patients. The Steering Committees recognise that being what is sometimes called an 'outlier' could simply be an indicator of potential problems rather than a definitive measure of poor quality of care. The registry cannot adjust for all known (let alone unknown) confounders affecting performance. Furthermore, it is statistically inevitable that 5% of sites or clinicians will be outliers even if their performance is not problematic. Because of the repeated measures, the chance of being an 'outlier' once is even higher. In addressing these matters, the Steering Committees suggested that management of outliers should be consistent with the extent to which failure to meet the indicator will affect patient safety. For example, an outlier on the indicator assessing in-hospital mortality should be handled differently from an outlier on the indicator assessing documentation of clinical T stage in the medical record. In addition, the Committees concluded that action should be escalated if there was a persistent trend, such as over two consecutive reports or a rate increase across two of the previous four reporting periods. The reports are confidential to clinicians and there is no mechanism to escalate management of these results.

Provision of Quality Indicator Reports to clinicians without a strategy for managing outliers is likely to have limited ability to change practice. This conclusion was reached in a systematic review of strategies for changing provider behaviour (Grimshaw et al., 2001). It was found that, while passive dissemination raises awareness of the desired behaviour change, it has limited effect on behaviour change if used in isolation. Grimshaw et al. (2001) concluded that effective behaviour-change strategies include using clinical champions and opinion leaders as well as audit and feedback.

It has been proposed that there are three basic factors that influence how well change is adopted (Berwick, 2003):

1. How the change is perceived by those expected to adopt it.
2. The characteristics of the people who adopt the innovation or fail to do so.
3. Contextual information influencing diffusion.

An important further consideration when trying to implement change in a healthcare environment is that it is a complex adaptive system in which people act in often unpredictable ways and where the actions of one person interconnect with the actions of other people, thus changing the context for everyone (Plsek & Greenhalgh, 2001).

Considering all these barriers to and facilitators of change, PCOR-ANZ and USANZ recognise as their cardinal priority that they must use the data provided by clinicians to promote optimum patient care. Their goal is to contribute to enhancing the relationship of each organisation to its clinicians so that the best outcomes are achieved for men with prostate cancer. The PCOR-ANZ Steering Committee therefore convened a working group in 2018 to recommend how to best manage outliers, prompted especially by the fact that Quality Indicator Reports were intended to be distributed within contributing jurisdictions by 2019. Contribution to PCOR-ANZ is voluntary. It is imperative that any mechanism for supporting and mentoring clinicians who fall two standard deviations below the mean is sensitive, respectful, and an encouragement to participate in PCOR-ANZ rather than a discouragement. The aim of providing reports is to promote quality improvement of all urological surgeons, not to act as a punitive measure to stop people practising in prostate cancer.

The working group determined that responsibility for dealing with outliers would be most appropriately managed by local jurisdictions. USANZ remains a professional entity for education and support. Legal counsel for both USANZ and Monash University (as data custodian) advised that, to protect any potential activity undertaken by USANZ, it should be conducted under Qualified Privilege (Department of Health, 2014). Qualified Privilege is embedded within the *Health Insurance Act 1973* and the *Health Insurance Regulation 1975* and enables healthcare professionals to disclose information without fear that it may be used in medical negligence litigation. While recommending that USANZ should lead this work, the working group did not recommend how to define outliers, how to modify the content and context of the reports, nor how most effectively to embed change in clinical practice.

AIM AND OBJECTIVES

The aim of this research was for PCOR-ANZ to reach a better understanding of medical specialists' responses to Quality Indicator Reports and of the best way to manage clinicians who fall more than two standard deviations below the mean. Management might include a mentoring program. It was also sought to identify any differences in opinions about the report and mentorship that arise from where clinicians work and whether they have previously received reports.

The objectives were to enhance the registry's ability to interact with clinicians and to improve patient outcomes.

METHOD

HUMAN RESEARCH ETHICS

Approval for this research was granted by the Monash University Human Research Ethics Committee (project ID 21674). It was assessed as low risk.

QUALITATIVE RESEARCH DESIGN

Because the research sought meaning and understanding, a qualitative research method was the most appropriate (Hammarberg et al., 2016). This approach is designed to encourage participants to reflect on the topic being investigated without restricting them to fixed response options; unexpected outcomes can be accommodated. Qualitative research usually aims for depth of evidence from each person rather than for a large number of participants. It can reveal unexpected results and nuances that cannot be captured in quantitative research where all variables and possible responses are known in advance. Because the research sought personal reflections on a particular professional topic, semi-structured interviews with key informants were judged to be apposite (Hammarberg et al., 2016).

SETTING

This research was conducted in jurisdictions contributing to PCOR-ANZ.

RECRUITMENT

Medical specialists were eligible for inclusion if they were members of USANZ and treating men with prostate cancer in Australia or New Zealand. Contribution to PCOR-ANZ was not a requirement for invitation to the study; it was hoped to recruit clinicians who did and did not contribute to the registry. In addition, we sought to recruit clinicians who did and did not receive a quality indicator report produced by PCOR-ANZ. Our commitment to seeking diverse perspectives meant that we targeted clinicians with varied urological experience, sex/gender, country of birth, and rural/metropolitan practice, as well as those who came from at least four jurisdictions: Victoria, New South Wales, Queensland, and New Zealand. In qualitative research, the goal is not to compare different groups but to represent a wide range of perspectives. It was expected that a maximum of 20 participants would provide sufficient data to address the research objective.

An invitation was distributed to clinicians who were members of the Urological Society of Australia and New Zealand (USANZ). The letter of invitation from the president is Appendix A. USANZ administers the Surgical Education and Training (SET) Program in Urology through the Royal Australasian College of Surgeons and organises Continuing Professional Development activities for its members. Further recruitment activities were undertaken: A call for volunteers appeared in UroNews on 17 July 2020 and was subsequently listed on the USANZ website; the president called for volunteers at the Annual Scientific Meeting of USANZ in 2020, emphasising the need for NSW informants; and members of the research team alerted their associates to the research, with attention paid to recruiting female clinicians. It had been planned to include a flyer with the Quality Indicator reports sent by the Registry, but this became one of the casualties of the communication problems instigated by COVID-19 and the associated restrictions.

A copy of the Explanatory Statement and Consent Form (Appendix C) was emailed to clinicians who expressed interest in the research. Those who then volunteered to participate were asked either to return the signed consent form or to give formal oral consent, to be audio recorded, at the beginning of the interview. An appointment was made at a time convenient to each clinician for an online (Zoom) interview. An honorarium of \$100 was offered to participants.

INTERVIEWS

Interviews were conducted by senior researchers (MK and JF) experienced in qualitative interview techniques with key informants. They used a study-specific interview guide (Appendix B) which invited participants to reflect on the Registry, the value of Quality Indicator reports, the identification

and management of 'outliers', and a potential USANZ mentorship scheme. The guide was designed to encourage clinicians to reflect on the topics and to pursue relevant matters of importance to them, rather than to limit them to researchers' expectations.

Demographic details were also collected: Years of urological practice; jurisdiction where the clinician practices and whether that occurs in metropolitan, regional, or rural areas; whether or not the clinician contributes to the Registry; and whether or not the clinician sees their Quality Indicator reports.

With participants' consent, interviews were audio-recorded and transcribed.

ANALYSIS

Interview notes, audio files, and other documents relating to the study are stored on a Monash University password-protected shared drive which is backed up nightly.

Audio files were transcribed using the Audio-to-Text Automated Transcription Service (TEMI: temi.com) and then manually checked against the recording by the researchers (MK and JF). The corrected transcripts were amended to delete or disguise details that could identify the participant. The researchers analysed the anonymised transcripts thematically using a well-established iterative method (Braun & Clarke, 2006). They searched the transcripts first to identify themes inherent in the interview questions and then for unexpected themes. The final hierarchy of themes was discussed within the project team until consensus was reached.

RESULTS

PARTICIPANTS

COVID-19 and its associated restrictions caused a resistance to volunteering; we were told this directly and indirectly by many medical specialists we approached. Nevertheless, 12 clinicians were interviewed, six by MK and six by JF. Most practised in Australia (five Victoria, four Queensland); the remaining three practised in New Zealand. We were unable to attract volunteers from New South Wales. Four of those from Australia and one from New Zealand worked in metropolitan areas, two from Australia and one from New Zealand worked in both metropolitan and regional areas, two from Australia and one from New Zealand worked in both metropolitan and rural areas, and one from Australia worked solely in a regional area. Their length of practice ranged from five to 30 years, with a mean of 18 years. We were unsuccessful in recruiting women, who were among those who cited the challenges of living and working with the concomitants of SARS-CoV-2.

The participants were thoughtful and spoke in detail about all matters of interest to the project. Interviews took from 19 to 32 minutes with a mean of 27 minutes. Results of the thematic analysis are presented under the headings 'Prostate Cancer Outcome Registry', 'Quality Indicator Reports', 'Proposed USANZ Mentorship Program', 'How to Improve Reports', and 'Additional Comments'. Results in each of these themes are briefly summarised at the end of the Results section. The participants are represented by a code incorporating their interview number, location (NZ, V, Q), and their area of practice: metropolitan (M), regional (Re), or rural (Ru).

PROSTATE CANCER OUTCOME REGISTRY

Ten of the participants contributed to the registry, and had done so for various periods of time from its inception to about a year. The registry was identified as being fundamental to improvements in standards of care and of practice. Benefits to patients were said to stem from "the relationship that you could potentially draw between the outcomes and the way that men were looked after, and where they were looked after, and what they had originally" (1VM). Optimal patient care arises from improved clinical performance through "the feedback loop in terms of how you get results and how you improve on those results" (3NZMRe).

I think just from a quality assurance point of view, and being able to, you know, improve your own figures and stuff like that, I think it's, you know, it's a really important sort of strategy. (12VMRe)

I think it's ... the best tool you've ever had to look at the nature of prostate cancer diagnosis and practice in, well, initially Victoria, but now Australia and New Zealand. I think it's invaluable. (11VM)

[In setting up registry], our aim was really to improve the outcomes of the patients, but also provide some sense of quality control and feedback to the clinicians, as well as to how they were going and ways to try and improve. (3NZMRe)

One interviewee summed up the esteem in which the registry is held:

This PCOR registry grown out of Victoria, catapulted into a binational thing with Movember, is incredibly high quality, a valuable initiative, you know. It really is compared to international standards. It's just outstanding, it truly is. I think it's something we should be very, very proud of and those funders who enable it. It is incredibly important what it does and I enjoy it because, you know, the papers we publish out of it or the Movember annual report now is an incredibly important contemporary snapshot of what's happening in prostate cancer across the place, not just in this big ivory tower or that one or whatever. The whole place. And the PROMS. (10VM)

A few clinicians demonstrated their commitment to the registry by analysing data and publishing the results and supervising postgraduate student work on registry data (e.g., 10VM, 11VM). One of these clinicians was concerned that these “incredible data” were being “underutilised” (11VM). He suggested that PCOR was “underfunded to actually consolidate the data and start analysing it and actually use it for what it's meant for” (11VM). Another clinician said that the MRFF should fund registries:

You'd fund a whole team of data managers. I mean, they have a million people answering phone calls about prescriptions. I mean, why can't you have a whole bunch of people actually helping with the data management? And you have a very clear both consent and qualified privilege process regarding the management of quality registries. ... It hasn't happened, but it needs to happen. And you have one set of rules that supersedes the states. ... If you have government approval for this registry, it is automatically accepted by every ethics anywhere. Instead of this nonsense of, 'Oh, it's approved by Monash, but now you've got to submit it to Cabrini,' or 'You've got to submit it to Epworth.' So you've got to submit it. It's just dumb. You should be submitting the approval and it just gets rubber stamped and it's done, you know? (12MRe)

There were comments on practical aspects of the registry, including the necessity for clinician involvement in its management because “decisions are made by people who participate” (2QMRe). The practical process of data collection was commended: “Staff come in and they collect data off our electronic medical records. That seems to be seamless: polite staff, efficient data entries” (4QMRu). Participation in the registry was also identified as a useful source of CPD points:

Every time you get your CPD from a college, and they say, Do you participate in audit? I just write, every time, 'I'm a signatory to the prostate cancer outcomes registry in which my data is de-identified, tabulated, and compared to all other signatories from around Australia', and that's it; that's your audit done and dusted. (4QMRu)

A few concerns were raised about the registry, along with suggestions for improvement.

We just need to keep fine tuning it and working out what its utility is to better serve our members and help the public, but not to vilify and punish people. (4QMRu)

Another concern is that the database does not recognise the difference between active surveillance and watchful waiting; local definitional variations mean that applying a definition from one context to another is likely to result in erroneous metrics:

Watchful waiting tends to be used in either the elderly, where you don't want to undertake radical treatment, or in those whose tumour is not suitable for radical treatment, but they're not really at the stage where they need either chemotherapy or hormonal therapy or some advanced management. And you're just observing them with blood tests. Active surveillance is a way of taking the low risk tumours in a group where you normally would treat them radically and saying, we think the chance of this progression is very small and therefore we will follow you with a mixture of blood tests and re-biopsies. ... Now we have our local criteria and ... every patient is put on active surveillance. We have very, very few that would ever be treated. And that's only because they're adamant they want treatment. Whereas it looks from the registry as though we are underperforming in that area and treating more people in that group radically. Now I think part of that that whole question of your local definition of the appropriate groups. And there are hundreds of different definitions of active surveillance. So I think that that's the one area that I see there's a little bit problematic. (6NZMRu)

A matter mentioned by one clinician but perhaps more widely applicable is the desire to protect patients from being denied insurance. This clinician said that he sometimes uses non-official coding terms to avoid a formality that might prevent his patients from receiving insurance. "There are some issues medico-legally when we give somebody a certain clinical assessment; that can sometimes preclude them from their trauma cover payouts. ... It's not a major issue" (4QMRu). This action, designed to assist patients, might lessen the specificity and thus usefulness of the data.

The matter of trust in the way in which registry data might be used was raised by contributors and non-contributors. For example, it was said that clinicians outside major cities might suspect that data could be used to redirect patients away from regional clinics.

Losing patients to the city is a thing, and people are very sensitive to it and we are, too, very sensitive to it, being a group that we tend to get second opinions. So, you know, people lose people to us all the time. So we very much try to message back out that, you know, you're going to have excellent care where you are and there has the advantage of being closer to home. But sometimes, for example, in prostate cancer, people want to come into the city to get access to robot surgery, for example, or they've done a bit of Googling and realised that high volume specialist centres do better, and so on. So we're very, very sensitive to it because we would never go out on a platform to say, I mean, although this might be true that high volume centres will deliver better outcomes for your patients, but in Australia with the way we have to deliver care across the regions, we're not going to go and say that out loud. But it's an understandable concern that people have and a vehicle like the registry exposes that a bit. (10VM)

These realistic concerns can, however, be assuaged:

When you go to certain individuals, often outside the big city centre, [they ask], 'What are you doing with this data? Why, why, why, why, you know, why do you academic people in the city want to know what my outcomes are?' And so on. But then, once you show them the value, especially, I think, the clinician reports. We often show them an example of a clinician report. Sure, it's de-identified and so on. And the depth of it. Then there's often a buy-in, you can turn people around. (10VM)

Non-contributing clinicians explained reasons or possible explanations for not being part of the registry. One said that the previous director of his department mistrusted the registry process, perceiving it to be a disguised mechanism for centralising urological surgery in major metropolitan centres and closing regional services (7QRe). He had himself heard at conferences arguments in favour of centralising treatment that he thought would have influenced the previous director:

[There is] a group of sort of urologists who are very heavy on the idea of centralising to high volume centres and high volume surgeons, which, when you're working sort of regionally, that's quite, sort of, confronting and it's insulting, too. We all have the same training. Some of them might've gone overseas to do their sort of their fellowship training, but I think sort of, by and large, we all have the same goal for the same patients. (7QRe)

He noted that:

Your patients don't want to travel a lot of the time from some regional places. But, I mean, if there are complications it's better to be dealt with in the same place where they've had their surgery. ... When the robot first started, there was a lot of patients would travel to Sydney or whatever, have the surgery, go home, and then get their complication. And then, who's going to look after him? ... [He'll] turn up to your local surgeon, who'll say, 'Well, I didn't do the surgery. I don't know what they've done.' So yeah, it becomes quite difficult. (7QRe)

Nevertheless, this clinician is prepared to consider contributing to the registry and made suggestions that he argued would make it more useful to him and his colleagues. These are to use pooled data of outcomes from regional and metropolitan services to assess patterns difference and why they might occur, and to record patients' characteristics (such as BMI and comorbidities) at the time of surgery because of their significant effect on outcomes (7QRe).

Two participants reported that they contribute data without being actively involved (8QM, 9VMRu). One assumes that a person in his practice gave permission "some time ago" and that someone comes into the practice and "scrapes the data" from his records. The other receives reports without actively contributing, and wonders whether the hospital where he operates or the state Cancer Council contribute his data. Rather than being concerned about not having consented to the process, this clinician said:

I was kind of grateful to get the report because it gave me something to look at. It was kind of useful, but it must be, as I said, there must be a health district service that looks into these things. I do practise at [NAME] private hospital and they've got a big prostate cancer service with prostate cancer nurse and support. And it might even have something to do with [NAME] Private, but I've had people that have been operated on in other hospitals too, that have gotten onto the registry. So, I must say, I don't know how they get there, but they get there and it all seems very efficient if I don't have to input anything. ... I am glad I'm contributing without actually contributing. (8QM)

QUALITY INDICATOR REPORTS

The value of the registry was directly linked to the reports it generates. Eleven of the participating clinicians receive the six-monthly QI reports. This includes one who does not actively contribute to the registry (8QM). The twelfth participant neither contributes data nor receives reports (7QRe). Participants commented on the value of the reports; what clinicians should do when they receive reports and what they actually do; the meaning of high and low QI scores; appropriate terminology for a clinician who scores more than two standard deviations below the mean; what a clinician should do and does do on receiving a low score on a QI report; what would be most useful to a clinician scoring more than two standard deviations below the mean; and what USANZ could do to help them.

Value of Reports

The reports were commonly assessed as valuable because they presented an opportunity to ensure "that men with prostate cancer would be a happier and healthier in the end" (1VM). To accomplish this, they work through clinicians:

I think the big role of these reports when I get them is ... it benchmarks me personally and makes me want to improve. (2QMRe)

Some participants said that they use the reports in discussions with their patients.

I do, I think, if not the most, the top three prostatectomies per year in [my city] and it frustrates me when people are coaxed into having surgery or having treatment that ... was not [the clinician's] area of expertise. And I think the Prostate Cancer Outcomes Registry is a nice way of being able to demonstrate the volume of work and your outcomes in an independent fashion. So I think, from that point of view, I find it invaluable and I use it whenever, when I'm counselling patients about my outcomes, my volume, just to reassure them that they're seeing someone who, this is in their field of expertise. (11VM)

Because I've got this PCOR data behind me now, I'm a lot more confident when I talk to patients about erectile dysfunction, urinary incontinence, cancer cure rate, positive margins, you know. ... What it means is that I'm confident that the operative technique that I've personally developed over the last 20 years is appropriate. ... My group had

collected an enormous database over the last 20 years. But it's good because this time it's now collected independent of me. So any biases that may be there or biases that external people may perceive, I'm comfortable that they can be extinguished. (2QMRe)

There was a feeling in a few cases that it might be difficult for clinicians to evaluate their own work.

I'm interested to know about my own outcomes, because I think surgeons are really poor judges; you know, you're exaggerating in your mind about how much you do and how bad you are or how good you are. So it's good to have an objective evaluation of things. (5NZM)

Similarly, a few clinicians found it helpful to be measured against their peers' performance.

I was kind of grateful to get the report because it gave me something to look at. ... I got into the pictogram-type data presentation. It made sense. And what I thought was, it's very interesting that I'm not the busiest prostaticologist, but I'm not the unbusiest either. I'm kind of in the middle. ... It's useful to get a feel for whether you are doing enough to remain current with the practice, or whether you think that you're an outlier. (8QM)

Response to Reports

How Clinicians Should Respond

It was generally accepted that clinicians should use the reports to reflect on their work and to take steps to improve it if necessary. The attitude is succinctly summarised as: "In the perfect world, the clinician will receive them, they will reflect, and change practice if needed" (2QMRe). Some participants also recommended discussing the reports within a supportive working team. For example:

The idea is that they look at the reports and they reflect on how they stand in comparison to peers. And they think about where they, perhaps, are not doing quite so well. And they reflect on things that they do that lead to those not-so-wellness in terms of outcomes. And they talk to their colleagues or to their managers or to their, whatever. ... They would have a desire to think about them and to think about how it applies to the patients they look after and then realise, actually, it's showing some signals there that they could do better. And then they would wash and repeat. ... And they put in place measures to improve the places where they're not doing so well. ... Ideally, you would have a quality assurance unit within the hospital, and ideally they would also encourage subsidiary units within each unit and they would support and resource them and encourage them to actually do quality assurance. (1VM)

How Clinicians Do Respond

Some clinicians report that they and their colleagues do what they advocate as the appropriate response to the reports. This includes carefully assessing their own reports to identify the improvements in practice that come with experience (e.g., 12VMRe) and group discussion of results.

In our department, we actually share our results, individual results, with everyone. So we all know exactly where everyone sits and, clearly, the idea of this is to try and learn off others. So if someone's doing better than someone else in the department, the reasons behind that need to be sought out. And that sometimes it's not related to the surgeon and it may be related to the types of patients they're seeing, but at least you can learn from that and work out different ways to evolve in terms of your practice and make it better. Now that's not something that, unfortunately, everyone's prepared to do. Our department's probably pretty unique in this. ... Ultimately, if you're going to have a feedback loop in terms of the outcomes and the results and how to improve the results, I think, really, unfortunately, you've got to have that. It's a crucial link in the chain. (3NZMRe)

No one wants their dirty washing to be aired, but I know we might be unusual in this regard, but for a long time, we've had very open audit system. It's not about blame. It's about trying to improve. It's a very tight department. ... Everyone has to play by the same rules. I don't know how common that sort of treatment of the data is, but certainly locally, it's all up for grabs. For example, ... one of the private providers ... have a PROMS that they record more around, you know, were you happy with the outcome? How it was treated, and all that stuff. ... They only send that to individual surgeons, but we've actually gone back to them and just got a data dump with identified surgeons across the group to look at, you know, are there any areas that are consistent, any themes, and are some people clearly deficient? ... And how can we look at changing that? (6NZMRu)

[I am part of] a group practice mentality, where we have always operated together on difficult cases with taking counsel from each other. ... I think it's very important that you know where you sit within your cohort and that you strive to be as good, to use the data in a positive way. ... I think it's really important to be transparent, ... [but] people are a little bit reticent to just put their results on the table and discuss it. (4QMRu)

I have actually shared my report with a couple of my colleagues. ... I've done that mainly in the context of giving them confidence that it's the right thing to do. ... The next phase of that is to try and share my experiences, which is what this is about, really; encourage recruitment [into the Registry]. (2QMRe)

Some clinicians described changing their practice according to their results.

Every time I get them, I do change my practice. ... Patients who report extreme bother, they're highlighted to us and I've made it my practice to then, specifically, get in contact with those patients and walk through what's bothering and how we can help them. And that needs to guide further treatment as required. (2QMRe)

I don't think there's any doubt it's practice-changing. So there's no doubt if you get data back that would suggest that you're not doing well in a certain area, you will almost certainly take steps. I think you've got proof of that because, if you look overall at the registry and the rates of active surveillance for men with low risk disease, that rate of active surveillance has gradually increased as time goes on. ... Some of that may have happened anyway, if you're all of a sudden an outlier [in specific areas]. ... [You think], 'I'm actually operating on a lot of these patients that my peers are not operating on.' It might make you think, 'Okay, it's actually okay for me to actually not treat these guys.' The same with margins, that doing nothing other than what we've been doing has actually dropped the margin rates. And interestingly, even in my own figures, you know, I've seen my PT2 margin rates drop through the years, too. That might mean I'm just doing the operation better, I'm selecting the patients better, but whatever it is, you know, you're very pleased when you see it's going in that direction. (12MRu)

Other participants were less confident that behaviour reflected the ideal. Despite never having seen a report, one participant suspected that a common response would be defensiveness.

Some people would be, I think, potentially sort of quite open to the feedback, but I think there's a reasonable number of people who potentially would try and find some way of justifying, or saying, well, that's because I had a particularly bad bunch of patients, or I take on the tough cases, or whatever. So I think there'd be certainly a cohort of surgeons who potentially may react sort of like they'd get the results and just either ignore them all, sort of, or sort of justify them in some way. (7QRe)

One participant described being less attentive to the reports as he became more familiar with them.

When they first came out, they were something novel and interesting, and gave me a sense of, I suppose, where the outcomes were for patients that I had been involved in their treatment. I suppose that, as time passes, they perhaps become a little bit less interesting, especially if they're pretty stable. Now, having said that, if I did look at them and noticed a bit of a shift and a worsening, particularly of outcomes, then I'd be pretty concerned and I'd probably want to try and figure out why. But I haven't noticed that to date. (9VMRu)

A few participants were concerned that the potential risk of making known the contents of the reports discouraged people from seeking guidance for a poor QI report and contributed to lack of action.

[Although] generally these things are best managed in a group, and discussed in a group, ... if there's some sort of publicly available information about outcomes, then that could be potentially detrimental to you. (3NZMRe)

It's really important to be transparent. The PR problem is, you know, there are so many competing things that can happen now. ... They'll have some concern about being compared and who gets that data and do administrators get it to governments. And, ... if you have a bad outcome, you end up in a public trial. ... So people are a little bit reticent to just put their results on the table and discuss it. ... I'm sure there's a number of people that don't keep databases and don't keep outcome data ... because they're fearful of having that data out there. (4QMRu)

One participant summarised his assessment of the likely range of responses:

Not everyone downloads the report, so now they typically get, I think, a link to be able to download these over a secure connection rather than get it in the mail. They'll get it emailed to them. ... I think, perhaps, a third of people don't look at it at all. And then another third might flip it. And another third might read through it with some interest, and a small fraction of that would actually take it and start to talk to their colleagues about it. But then it changes over time, too. I think that it depends on how busy people are. ... Some people might read the reports with more interest now than they did in the past, or vice versa. (1VM)

Meaning Of Scores In the Report

Participants were asked about what it meant to have a high or low score on the QI reports. Some commented in general:

It's the same argument, whether you're above or below, what the cause of that is, whether it's case selection or truly poor practice. (2QMRe)

I still have some questions about it because the top performing, you know, three or four years ago, are now the bottom performing, and it doesn't make sense given that no-one's really changed anything. ... Maybe it was case selection. Selection's important, and particularly around nerve-sparing. So maybe your answer's there, and it's something that we have on the agenda to look at, but haven't done yet. ... I guess I'm a little sensitive, having been one of those to see a decline. ... I only work half time now. So my caseloads are reduced, which potentially could be an issue, but I don't perceive a difference in technique. But one of my other colleagues who still does a lot of work, [NAME], was the highest scoring by a long way, has dropped to be second bottom now, and that doesn't make sense. ... [Those with a high reputation] may have started trying to nerve-spare less often. And this is delicate balance. ... The more you spare those [nerves], the more likely you have positive margins going up. ... And this is one of the things I think that I hope we'll get out of ... looking at the operation notes, because in those operation notes, that field has to be actively filled. ... People often

don't mention whether they did nerve sparing or not. So you're often left with incomplete data. (6NZMRu)

Higher Scores

What it might mean to have a higher score was sometimes related to surgeons' desire to be the best and sometimes attributed to circumstances.

As a general rule, most surgeons are pretty competitive, so they clearly want to be one position, which is usually number one. The idea is to try and create, not competition, but at least feedback of where you sit in the group. ... If someone's doing better than someone else in the department, the reasons behind that need to be sought out and that sometimes it's not related to the surgeon and it may be related to the types of patients they're seeing. But at least you can learn from that and work out different ways to evolve in terms of your practice and make it better. (3NZMRe)

It was said that a high score was evidence of good practice and an encouragement for greater achievement.

When you see good outcomes, ... I feel like, okay, I'm doing a good job. ... It actually encourages you to do slightly more complex cases that you otherwise would not take on. And that's what I found: that really I was okay. ... I keep a record of some stuff myself and maybe just expanding the locations, you know; maybe a bit more obese patients' prostates. And I do think it does make an impact. (5NZM)

High scores associated with particular places were cited as exemplars for others.

Part of their rationale, actually, is to find which centres are actually achieving the best outcomes and then figure out why. And then that gives us a chance to emulate that, whatever it is they're doing. (9VMRu)

A few participants expressed concern that high scores lent themselves to good publicity and that clinicians who scored well would use that as a marketing tool.

I think it's very important that, you know, where you sit within your cohort and that you strive to be as good to use the data in a positive way. My slight concern with it [is that] ... there are some colleagues ... that are basically using where they sit on the data to advertise and market themselves. And I don't think that's a very productive outcome for the database. ... I don't know if, when you sign up to something like this, that you can put in legal clauses that say you shouldn't have on websites where you sit in it and things like that. I'm not sure how that could be exercised, but I don't like it being used in that respect. (4QMRu)

I think what you do about the very good surgeons and the very bad surgeons, I think, is problematic, because the good surgeons are good, and that's great, but there is obviously the possibility that they will use it as a marketing tool to take cases away from the less performing surgeons. ... That's one thing that's always worried me a little bit about people sort of turning around and saying, 'Well, you know, here is my dot. Look, these are all of my other peers', ... and they use it as a bit of a marketing tool. And whilst I've not actually seen real concrete evidence that it's been on someone's website or something, but it would worry me that at some point, they're going to say, ... 'These are my data in the prostate cancer registry. And I'm doing better than, you know, all of these.' ... I think there needs to be an agreement for the contributors to the registry that the results that are transmitted back remain confidential. ... You're never going to stop them saying things to a patient in a room and no one's going to be there that'd be able to control that. What I don't want to see is it's on someone's web page. And I just think that there needs to be a very clear confidentiality agreement to say, you

know, if you're doing well, that's fine, but you can't stick that on your website, basically. (12VMRe)

Lower Scores

Participants were aware that someone would inevitably be at the bottom of the distribution.

There have to be outliers. ... That's just the way it is, isn't it, when you have a distribution like this. Interestingly, you know, it was set up as a quality registry, and part of the purpose of the reports is to feed back so people know what their margins are and how they compare to others, so that you can look at them. Because a lot of people don't know. ... Interestingly, over the 10 years of the registry, all the quality has been improving. So that's very reassuring for society, for the funders, and for everybody else. Should be reassuring for the outlier as well, that the reason he or she is there is because the standard has been rising. (10VM)

Lower scores, it was said, might be an artifact of case selection.

We deal with this extensively in the public hospital system. If you're the surgeon that treats the high co-morbidity patients, the older patients, the patients with diseases that have more complications, the surgery is riskier. Then you have a name that looks like a nightmare compared to somebody who's just doing hernia repair. So you have to look at the cohort that the surgeon is treating. And I know we correct for that, but that can skew the data. (4QMRu)

One of the problems of course, with this, the quality-of-life data, is that we don't have preoperative data. So you don't know, for example, what the correlation with the preoperative parameters are. So, for example, and I know this happens to me, I get referred difficult patients by my junior colleagues because they don't want to take them on for various reasons. And so I may get patients who were more likely to have positive margins, who are perhaps a little more demanding. Now that sounds like me making a special case for me being below average but, you know, what I'm saying is that it may well be case selection. ... For example, I know patients who are referred to me from certain geographic areas do worse than other geographic areas. ... We know that there's different disease processes or presentations is that there are plenty of other explanations for these variations. (2QMRu)

The first thing is ... the extent to which we can identify them. ... It's not clear from the outset that just having the quality indicator reports, that show, for example, performance ... two standard deviations away from, three standard deviations away from the mean is sufficient evidence that actually there's something going on there because, in fact, we're already looking at, I don't know, 20 quality indicators. And so, you know, if you're just looking at a distribution engine, doing 20 tests, you're going to find that there will be one or two people who will be outside three standard deviation from time to time. So having one sample doesn't at that time mean that much. And so you need to watch it over time. (1VM)

Low scores might also be sheeted home to a clinician when the procedure was performed by a trainee.

When it comes to the criticism, what if somebody's training registrars, encouraging them to do most of the operation? And they end up having worse outcomes. The first thing that people are going to do is they're going to stop letting registrars operate. And that's very important because training is fundamental. So it's something to think about if you're going to give feedback: how are we going to separate the consultant from the registrar? ... I think they should have a better way of capturing maybe what percentage of this operation was done by a registrar. (5NZM)

Cases of poor performance, it was said, must be recognised.

It's really the outliers at the bottom that's potentially the problem that we need to solve. ... If someone is seeing a number of patients and sits well outside the norms, and that information is available to the head of department, then there is really a moral obligation and a humanitarian obligation to do something about that. ... My impression working in a lot of departments around the world is that everyone knows that someone's a poor performer, but this just makes it more obvious and documents it. (3NZMRe)

The bigger, more concerning ones are the ones who are sort of at the bottom end of the curve. And so trying to figure out, is it a technique issue? (7QRe)

A low value as you've identified does not necessarily mean a bad surgeon. It may just be harder cases or about case selection as much as anything. ... People either within the range or they're a clear outlier. Most of the clear outliers, I think, probably have technical deficits. You know, when I talk about our group moving around in terms of their ranking, everyone's still within the range. Whereas we did at one time have a clear outlier. (6NZMRu)

It was said that is important to identify the parameters that define a surgeon who is performing poorly.

How do you define someone who's not performing well? Because what if their margin rate is good and their continence rate is good, but their potency isn't? Is that a good surgeon or a bad surgeon? What if it's great continence, great potency, but their margins are a bit higher? You know, what does that actually mean? So to me, the first problem that we've got is how you define an outlier and, to me, an outlier is someone who probably fails in all of the parameters. So if you've got someone who's, you know, got a high PT2 margin rate, their continence isn't very good, their potency's not very good, that's a sign of someone who needs a bit of help. (12MRe)

The meaning of a lower score was sometimes assessed as suggesting that surgeons with low volumes should not perform certain procedures.

If you were really serious about looking at outcomes, you would do what the UK has done and actually start saying that those surgeons who are doing prostatectomy actually need to have a certain volume a year and actually need to have done a certain period of training to do the operation themselves. So the UK have now centralised cancer care for this reason, and not only prostatectomies, but nephrectomies, cystectomies, all had to be done at high volume centralised centres. And that was the way of stopping these outliers, making sure that people weren't doing five a year and getting bad results. Until you have that sort of system, you're really just playing around the edges. ... The culture [in Australia] has been one of, well, once you've got your urology ticket, you can actually do any procedure in the book, any procedure, whether you've actually been trained to or not. And that becomes quite apparent in some procedures, like a nephrectomy, where, if you do it badly, someone dies. ... With prostate cancer, it's a bit less subtle because you don't kill people, you just maim them, outliers, and so you render healthy men incontinent, impotent, the cancer comes back, they have radiation therapy and these things aren't as obvious because they're perhaps longer term complications that don't come under an item number or code that you can capture as a major complication. So the prostate cancer registry, for the first time, is capturing that. (11VM)

There was concern for clinicians who do not contribute data who might tend towards the lower end of the QI curve.

My understanding is by no means everyone has to sign up to contributing data. And so, probably, people who are happy to contribute data are self-selecting and therefore, you know, you're going to get a bias towards probably better outcomes, because most likely the people who are happy to contribute are not worried that they could be an outlier. ... The worst case scenario is really the people who would be outliers if their data was collected. And of course, we don't know, we can't know who they are. (9VMRu)

Is There a Better Term Than Outlier?

Most participants were unable to suggest a term to replace *outlier*. One suggested “exceptional” (1VM), although this did not distinguish the exceptionally bad from the exceptionally good; another “crappy surgeon” (6NZMRu). One participant (8QM) was surprised that it was considered a stigmatising term but another held the opposite view:

I think it's a horrible, horrible term. ... You don't want to highlight the bad aspects of the surgery. ... You want ... to suggest that they're emerging, they're on a pathway to improvement and we're looking to offer them that next step. So ‘emerging’ might not be the right word. They're not training. ... I want to say less experienced. ... There's a term, isn't there, and it has to be a word that says that the person has the ability to reach it. It's got to be a term that says they're not at the level of others, but they have the ability, with help, to get there. I'm not sure what that word is. (4QMRu)

Finally, a participant found it to be a malleable term.

I think Malcolm Gladwell turned the word outlier into a positive, actually. It can be a good outlier. ... I think I see it as being pretty neutral. ... It can be pejorative, but it also can be complimentary. So I think they kind of balance each other out. (9VMRu)

Action For Clinicians With Lower Scores

Clinician Response

Views on what clinicians with lower scores should do were an extension of what all clinicians should do when they receive their reports: reflect and act. “Examine your own practice and see, are there steps that can be taken to improve that measure?” (10VM). Action might include relinquishing certain procedures.

The idea is that they look at the reports and they reflect on how they stand in comparison to peers. And they think about where they perhaps are not doing quite so well. And they reflect on things that they do that lead to those not-so-wellness in terms of outcomes. And they talk to their colleagues or to their managers or to their whatever. ... And they put in place measures to improve the places where they're not doing so well. ... That's a whole range of things, ... from ... the structure and the financial incentives of the health system in which they work; it's the care and attention within the hospital, the clinic in which they work; ... the financial incentives and the HR incentives inside [the] ... team they work with. ... It's perhaps the personal reflection on judgment and in advising patients. And it's also, perhaps, patient-driven, ... with patients getting good care and better care and start to also drive part of that ... The way I see it is that at the clinician level, ... there are things that they can do within their control and the things they can't do. (1VM)

I would automatically talk to a senior colleague and say, ‘Hey, listen, I've been a bit dusted up here. This doesn't look so great. And would you mind going through my data with me and having a look?’ ... That's the beauty of being in a group practice with transparency. ... You just need to drill down on the data a little bit better. You don't need to change what the data tells us, but I think you need to drill down on it. And I certainly wouldn't just file a report in the bottom drawer and keep on keeping on. ... And I don't think anybody should. (4QMRu)

It's useful to get a feel for whether you are doing enough to remain current with the practice. ... I think you've got to sort of examine how you manage and decide for yourself whether it's appropriate to keep doing it, if you're an outlier. ... You would hope that a clinician who's practising mainstream sorts of treatment would look at it and say, 'Okay, I'm not doing that so well. Let's go and see if there's something that I can remediate.' That's what you would hope, but I'm not too sure whether the people who need that would actually even bother looking at those results. (8QM)

If you're way out in the standard deviations and you've sought help and you've had mentorship and you looked at your cohort and you've tried to case-select better, and you still can't raise yourself out of that mire, I think I would hope that people would have the fortitude to change what they're doing. Just stop. Just don't do the procedures. (4QMRu)

I think they should definitely be doing some sort of retraining. ... I guess you rely on surgeons to do the right thing. Like I said, there's plenty of opportunities to go and watch other surgeons, to see, to attend workshops, conferences around the world. It's never been easier to go to try and get tips and tricks from other people. (11VM)

It was common to distinguish matters the clinician could control and those beyond clinician control (1VM, 2QMRe, 4QMRu, 6NZMRu, list others).

I would firstly like them to look at that report and make sure the data's being collected properly. ... Make sure it's complete. ... It depends on the particular quality indicator. So if it's the clinical indicators, the quality of life, the problem type indicators, that would need a different set of reactions to, say, the mechanistic recording of TNM or recording a PSI pre- and post-op, one that can be fixed easily, whether it's a true surrogate of quality of care. I think that's a whole argument that we can have if you are truly two standard deviations. I would hope that that surgeon would reflect and then seek counsel. (2QMRe)

First of all, don't take it at face value. It really does, I think, need to be looked at in terms of what they're doing surgically. Are they nerve-sparing, not nerve-sparing? ... A low value as you've identified does not necessarily mean a bad surgeon. It may just be harder cases or about case selection as much as anything. So I think that's the first thing to do. But the second thing is, if everyone looks like their case selection is similar within a group, and it's easier to deal with within a group. I'm not sure how you manage this in an individual, out of a group. But if there's a clear outlier and yet the case selection and things looks to be the same, then it should be an open conversation, really about, okay, so what's going on? (6NZMRU)

If they don't believe the data, they should have it at their fingertips to go and mine it themselves. You know, if you had a quarter where you were put at the bottom end of say, positive margins, then I would be reviewing all those cases myself. ... Sometimes the data is collected in a way, you know, if someone does a biopsy and someone else does a prostatectomy, then it may be linked to you when you didn't do the prostatectomy, for example. So I can see how you would want to check that it is ascribed to the correct specialist. (11VM)

Some participants said that it is not always possible to know what clinicians actually do in response to a poor score. Others emphasised that they did not want to deter contributors to the registry and therefore did not enquire.

I've been careful not to ask clinicians. One of the sensitivities of this is the intrusion into that patient-doctor relationship, the Big Brother effect, if you will. I'm uncomfortable about doing that. ... I don't want to jeopardise recruitment in the use of this tool. (2QMRe)

It was frequently accepted that it would be difficult for a clinician to accept a poor result; they might ignore or reject it, claiming, “Well, the data’s bullshit and for these reasons it’s not correct” (11VM).

I think you have to have like two, maybe it’s two consecutive reports, you know? So someone who hasn’t had a tap on the shoulder, but they they’ve seen, ‘Oh my gosh!’ You know. And they probably would dismiss it saying, ‘Oh look, they don’t measure this correctly.’ Or ... ‘The data’s wrong.’ (10VM)

I imagine if I had one or two outliers that would make me wonder, like, why would I have worse pathological outcomes, worse functional outcomes? So I think it would have an impact. ... I don’t think a lot of surgeons would welcome that. ... There are other factors at play. ... There’s all this degree of competitiveness between different surgeons. Getting the cases in public or private and access to theatres is a lot of other factors, individual factors, and the personality within the department. And I think that would make things very difficult. ... I think it would overall have a negative impact on that individual. ... We are not used to it. We haven’t done it for anything else. And I think you get, some stage within your career, that you don’t take that sort of criticism very well. (5NZM)

Some people would be, I think, potentially sort of quite open to the feedback, but I think there’s a reasonable number of people who potentially would try and find some way of justifying or saying, ‘Well, that’s because I had a particularly bad bunch of patients,’ or ‘I take on the tough cases,’ or whatever. So I think there’d be certainly a cohort of surgeons who ... [would] just either ignore them all, sort of, or sort of justify them in some way. (7QRe)

The first reaction will be ... to deflect it. ... ‘It’s because I see the hardest patients’, ... ‘the nurses don’t do a great job helping me out in theatre’. ... I wouldn’t be surprised if that’s the usual first response. So there will be a bit of combativeness, I suspect, in most people that are singled out. And so I think the first thing is that people have got to be given the opportunity to improve themselves without being singled out. (3NZMRe)

None of our participants reported being an outlier. As one said, “It would be very interesting to speak to someone who is an outlier and hear their experience” (10VM).

Response of Others to Clinicians With Low Scores

There were diverse views on how others should respond, who has responsibility to respond, and the nature of the response.

If someone is seeing a number of patients and sits well outside the norms, and that information is available to the head of department, then there is really a moral obligation and a humanitarian obligation to do something about that. ... My impression, working in a lot of departments around the world, is that everyone knows that someone’s a poor performer, but this just makes it more obvious and documents it. (3NZMRe)

The reports also go, of course, in theory, to the quality assurance people in the hospitals. ... They can’t actually learn how to do prostatectomies better, but they can perhaps learn that they shouldn’t employ Dr. A. (1VM)

We did have to tap a big public hospital on the shoulder a few years ago, a big centre that—positive margin rates were shocking! And very pleasingly, you know, two reports later, they were bang back in, you know. The head of unit was tapped on the shoulder to say, ‘Look, your margin rates, this is what they are, you know?’ ... Because they often don’t know. Took some measures, you know, a bit more supervision training,

whatever it's going to be. So I think that's part of the messaging in dealing with the outliers. (10VM)

However, action by others might not be straightforward.

It's a tricky one because your average doc isn't going to take too kindly to someone who they don't hold as a mentor or a luminary getting in touch with them and saying, 'We don't think you're doing such a good job.' That that's just too confrontational. (8QM)

Clinicians were urged to assume responsibility for improving patient care.

In all honesty, if we don't do this ourselves, it'll be done to us. I use the word *to us*, not *for us*. Especially if the community sees that there is a problem. And I would think the community does see this as a problem, for a number of reasons. Firstly, there's a cost and out-of-pocket expenses. Now, if you're a person who's paying a lot of money to have something done and you get a less than perfect outcome, I would think you've got every right to seek an explanation: 'Why haven't I done as well as someone else, especially when I've paid so much money out of pocket? And you told me that you're very good at this.' So it won't take too many people doing things like that and then getting bad results, going to the health ombudsman. It's happening all the time. And then the health ombudsmen will decide, they'll form a committee, just like if, you will, the transvaginal mesh in gynaecology. ... Gynaecologists didn't blow the whistle on themselves, I can guarantee you that. It was the patients. And ... that might happen with prostatectomy as well. It could, especially with the modern technologies that are supposed to be so much better. You know what I mean? It'll be taken out of our hands. (8QM)

What might be most helpful to clinician with low scores

A common approach to helping clinicians with low QI scores was to give them an opportunity to improve and to take action if they failed to do so.

I think the first thing is that people have got to be given the opportunity to improve themselves without being singled out. (3NZMRe)

You watch courses, you contact someone, 'Can I come and watch you in Sydney?' ... That's actively taking part. They have a mentor, they can call someone, and someone that's outside the region. So, you know, maybe we want to keep it private. ... I think that would encourage the reasonable clinician to do something. ... It could be something that's there for all major complex procedures, you know, like some basic infrastructure of support. (5NZM)

I personally think that all medical data, wherever possible, should be utilised for good, for learning, for improvement. And there is so much waste of data that goes on. I just find it very frustrating, knowing how much juicy, useful data is out there that doesn't get used. So anyway, people who do contribute, I think, should not ever be punished, if you like, for having bad results, but they must be made aware. Then the second consideration, I suppose, is once made aware, then what? And that's when, I suppose, it would be, ideally, rather than just awareness, it would be preferable if that awareness could then be actioned such that there is some measurable intervention. ... It could be purely an external party having a conversation with that practitioner, saying, 'Why do you think, you know, you're an outlier? Why do you think this might be?' And then just trying to get to the bottom of it, no different to how we conduct clinical audit on a regular basis in the hospitals. ... It's not about punishment. It's not about, you know, shame-based learning. It's about just learning. (9VMRu)

A punitive approach was considered by the majority of participants to be unhelpful. An important reason was that it might discourage clinicians from contributing data.

It's still terribly important, I think, for the buy-in of the registry, as it's optional and consent driven, that people understand the messaging, and the governance of it is not a police force, it's just to feed back. ... I'll try and imagine myself, if I had to get a tap on the shoulder, ... I'd prefer to have that conversation with a trusted colleague. ... I think if you've seen your report and you look at that, you'd understand why a friendly senior surgeon, surgical colleague, will have a chat with you about it. (10VM)

People provide us with the data and, you know, if we were to say, 'Well, that shows that your career should be over. You should stop doing this and stop selling second-hand cars', people will just stop giving us the information. (1VM)

To be involved, people have got to have comfort that they won't be ... publicly singled out in terms of what the results are. And that's a very important part of the process that the results are confined to the individual, and perhaps the department and perhaps the country as a whole, so that, you know, everyone's comfortable contributing to the results because, obviously, people's livelihoods are on the line, particularly in Australia where it's much more of a business than in New Zealand. (3NZMR)

What I would like to see happen would be that you would identify those people. You'd have people that would then, in a legally protected way, be able to have a conversation with that person and actually say, 'Listen, we can actually put you in contact with some people who are high-performing surgeons, out of the registry, just to see if there's some tips or whatever that you will get that might improve your outcomes, so that we could watch what happens.' And the problem that we've got otherwise is that we don't want, let's say, someone in one six-month period having some bad outcomes, and it gets in the hand of a medical director who then ... misinterprets the data. They then use it in a punitive way to stop that person doing surgery. And then ... what'll happen is that all the contributors to the registry will disappear because they'll say, 'I would rather my details not be available because at least this way I can't be punished for it.' ... I think there needs to be a very clear, ideally legally protected, way of being able to look at the data, gently approach some of the underperforming surgeons, with, maybe, you know, for the completely intransigent surgeons, having a bit of a stick at the other end. (12MR)

It was posited that, although assistance and additional training would contribute to improved performance, they might be difficult to implement.

Have, you know, course training [such as] ... robotics courses. ... I think that they're helpful. I wonder about, if they start to scratch a little deeper, how that would be accepted in a perfect world. They could link up people and say 'Here's a cohort of surgeons that are getting terrific results. You're in a cohort some distance from that. There's an arrangement that you can link in with them and go and watch them operate and so forth.' But that's a bridge way too far away, because it's okay to act as the intermediary, but you've got to have the soldiers in there that are going to say, 'Well, yeah, well, I'm a great surgeon and I'll show someone who's struggling.' And I guess that's reflected in medical training, isn't it? Not everybody chooses to train and work in public hospitals and breed the next generation of surgeons. (4QMR)

It was acknowledged that helpful responses would need to be tailored to the clinician.

That's where it becomes a little bit more sensitive; ... how do you sort of approach someone who's not reaching their benchmarks? ... And who's got access to that information? ... The director of the unit, or whether it's, ... I guess, sort of not a professor, but the more senior sort of urology colleagues. ... That then becomes ...

how does that sort of marry up ... the confidentiality for each surgeon? ... Someone's going to have to be notified and there's going to have to be the corrective sort of process. ... The director of the unit ... is probably sort of potentially the best person. ... There's a couple of guys in my unit who've got miles more experience than I have, so me approaching them saying, look, I think your technique's not quite sort of up to speed may not necessarily be quite as useful. ... I think it'd be probably one of those things where you almost have to tailor it to sort of who it is, to some degree. (7QRe)

How USANZ could help those with low scores

There were clear differences of opinion not only on how USANZ should assist those with low QI scores but whether it was appropriate for USANZ to do so. Some participants were clear that it was USANZ's responsibility to act.

The theory is that we would have a group of wise men—and of course they are hugely men at the Urology Society. And that they would tap the person on the shoulder and counsel them. Perhaps invite them to come up and see how it's really done, or something like that. So there'd be some sort of mentoring and support for these people. We haven't yet thought about punitive measures and striking off the registry like that. ... In the long run, one of the questions, as well, is what's our responsibility? ... Do we have, you know, responsibility if surgeons are killing patients? We haven't, luckily, faced that problem, but it's worth thinking about what we do if we did. (1VM)

In the Urological Society, there's a crowd called special advisory groups or SAGs, set up, oh, 15 years ago, probably, for this reason: to have a committee whose remit is to be a portal between the Urological Society and the community. ... Now, whether they would be the appropriate people to turn that back in, so that the portal wouldn't be outside the Urological Society, it would be back in to the society. I personally wouldn't find that *that* threatening, but I can tell you that would be an issue for people who would think, 'Oh, Big Brother's watching me now. What am I going to, you know, what does this mean?' But there is no doubt that audit and a reflective practice involves critical assessment of your results. And that's essentially what this is. It's a critical assessment of results. And if you don't use it to your and your patients' advantage, well, it's just a waste of paper, isn't it? ... The people who are behind setting it up have spent a lot of time and effort accepting the fact that there'd be people performing to a substandard level. And they're just wondering, well, we've got all this data, what are we going to do with it now? (8QM)

One participant argued that USANZ ought to implement a strict training regime and ensure that surgeons performed only those procedures in which they were experienced and competent.

I love the registry because it holds everyone to account. And I like being able to show people, well, this is the volume I do. This is where I sit compared to everyone else. And that's why I put the effort into doing the type of surgery I do. But it's also why I don't do the other procedures. So I'm responsible enough to say, well, I'm not going to do multiple other benign procedures that urologists do all the time because I just don't do them. And I wouldn't do them as well. And so I focus on one procedure and what I'm good at. I think that's really what other urologists perhaps should be doing. But it's something that goes back again to training. You know, there really should be a, like the NHS: you finish urology with a basic set of procedures you can do. And then you do a fellowship training, in either uro-oncology or reconstructive work or stones or a BBH or whatever. And then that allows you to do the next level up procedures. But that'd be a pretty brave USANZ board to implement something like that because there'd be outrage across the country. ... It's the optimal model. It's the safest model. If I was a member of the public, ... or lay person, that would make sense to me, surely you'd want practitioners doing a procedure that they're most skilled and best trained at, as opposed to now, where people can just do one of whatever procedure a year and no one's regulating that because it's in the private hospitals. ... I haven't got a solution for

you because I get frustrated, when I talk about it, by the system. I just think it's a really poor system. When you look around the world and see how much better people are accredited, even around other specialties. So for example, ... in general surgery, you've got a specific colorectal society where, if you're a member of that, then that shows that you've done specific training and specific expertise, and you'd expect a better outcome than, say, a general surgeon who's just in the country doing right hemicolectomies. ... Other specialties seem to be able to implement these sort of tiered levels of accreditation. (11VM)

Some clinicians considered that it might not be the place of USANZ to intervene in all circumstances.

I think if you tell people, 'Look, you must, you have to do this,' that's not going to make anybody better. If I've been doing something bad for 10 years and somebody's telling me, you're forcing me to do something that I could be making a living off, ... it creates all sorts of complications and complaints. And, you know, you may end up challenging the authority. ... People lawyer up, essentially, you know? So I think that would create a big challenge for USANZ, without any gains; create conflict. (5NZM)

One participant preferred the PCOR over USANZ for making contact with a clinician with a poor QI score.

The problem with it is because it's all de-identified, you know, and if you're an outlier, you don't want it being discussed by a USANZ committee, for example. It really needs to be, I believe, a very tight communication chain, ... in at least in the first instance. ... If it turns out that there is a bit of a rogue person who has bad results, you know, then it's not even still a USANZ thing. That's a medical director thing in a hospital. They look after governance and quality and so on. So I'm not convinced that bringing it outside the registry would help, when in fact you have very good surgeons on the steering committees in each of the States who are usually senior, senior experience, with USANZ already; office holders and ex office holders and so on. But remember, part of the concerns I think outliers would have is a letter from USANZ. ... 'There's a USANZ thing on this now? I didn't realise USANZ were running this registry.' And not everyone likes it. Not everyone has good dealings with USANZ, and then, 'Are they the police now?' So I think it should be very, very, very tight. And just, the tap on the shoulder should come from the registry and from a senior clinician in the registry, who will hopefully be able to have a positive conversation. (10VM)

One participant weighed up the problems and possibilities of the role of USANZ, including legal and ethical concerns.

I think USANZ would be a very good broker, together with the registry, but the issue has always been, how do you—there needs to be a degree of legal protection. ... I guess the concern that they've got, first of all, there was this legal question of, is PCOR allowed to even share the data with USANZ? It's a different organisation. ... So I've always thought that it was legally safer to, if you're going to have a committee looking at this, it should be a PCOR committee with urologists in that. ... So you could have USANZ representation on the PCOR committee rather than it being a USANZ committee. Because I think then you're potentially breaking consent because you're sharing data outside of Monash Uni to another organisation. (12MRe)

PROPOSED USANZ MENTORSHIP PROGRAM

Eleven of the 12 participants endorsed the introduction of a USANZ mentorship program, although it was not seen as a straightforward proposition. This topic elicited the most detailed and lengthy responses, with diverse views on how it should operate.

Participants who had themselves used a mentorship scheme had found it helpful. One said that, in becoming an academic urologist, “I got support from my mentor who kind of had what, you know, what research needs is funding. And he had a big chunk of funding waiting for me” (5NZM). Another said that he had found post-fellowship mentorship to be “ad hoc” (8QM). A participant who had experienced both sides of mentoring reported mixed experience.

I have been a mentor through [a hospital]. ... This is nothing to do with urology, even. That's really just the interns. Aside from that, I have actively sought mentorship for myself, by seeking out various senior people who I felt appeared to have similar values to me. So I'm very conscious of the whole concept of mentorship and I'm a very strong advocate for it. ... As a mentor, [the hospital] put out an invitation. I said, 'Yep, happy to be one.' And I've offered that to a couple of interns. I'm not sure how particularly effective that was because they were random matches. I think that's a whole different style of mentorship, which has its pros and cons. I suspect mainly cons, actually, compared to more targeted mentoring. (9VMRu)

Others found mentorship akin to working collaboratively.

Early in my career, I did a lot of mentoring of radical prostatectomies with people because I've done a lot of them overseas and ... we'd do five or 10 cases together and I'd go through them. And when I thought they were doing them well, I'd say, 'Listen, I think you're okay.' ... And I've experienced it from other sort of procedures where people have come along and sort of showed me how to do different techniques; ... you then feel comfortable doing it and you can do it yourself. So I think it's a very valuable thing to do. ... It might even start fitting into the CPD criteria for the College of Surgeons in the not-too-distant future, because in your self-assessment for a year, you might say that, you know, you want to improve your outcomes with radical prostatectomy and you will have a practice visit by a surgeon mentor, and then you just do that. To tell you the truth, there's nothing more valuable. In the last year or so, some of my very major oncology cases I've actually done together with one of my other colleagues and we just do it together and it's really enjoyable. ... It's not that I can't do it on my own, but it's actually infinitely more pleasurable to do it. With someone skilled who can give you a hand. (12VMRe)

It was proposed that a mentor scheme, perhaps based on those in the top 5% of QI scores, should be available to all clinicians.

[A mentor] needs to be someone that is in the top part of the equation, because clearly, it's not going to be useful if the mentor's in the middle of the pack. What we want is someone that is actually getting the best results. ... And particularly, in a situation where the department hasn't got to a stage where you can openly discuss all of the results. ... What we want to do is actually have a national system. ... I'm sure that the people in the top 5% don't care whether it's known they're in the top 5%. But then that would mean that the people that know that they're in the bottom 5%, they'll know who the top 5% of people are. And then that will enable those people to have someone that they can go to if they want to improve. And certainly, if I knew someone in the top 5% I'd be going and seeing how they do it, what they do, what their practice is, how their department's set up, et cetera, et cetera. So that you can get a system going that is modelled on whatever they do, because presumably that would also get your results into a similar position. ... [The clinician would initiate the mentorship because] most people, hopefully, in that position would feel a sense of 'I need to improve'. And if ... there's a system in place, you know, where you know ... these four people are in the top 5%. And Mr. Jones is in Christchurch, Mr. Smith's in Auckland, and they're available to talk to and discuss their results and how they got to that point, and you can go and observe them doing this. Then I would see that as an opportunity for those people. ... I'm probably in the top quarter, but even being in the top quarter, I'm not in

the top five. I want to be in the top five. So if I knew who those people were, I'd be going and observing them and seeing what they do differently. (3NZMR)

Somebody maybe has good outcomes, but they want to do better. Then everybody can have the process. ... There could be a list of mentors, right? Volunteer; like, 'I want to be a mentor.' ... You [the person seeking a mentor] opt in, but you give this option that's really easy. ... It could be something that's there for all major complex procedures. (5NZM)

It was suggested that a USANZ mentorship scheme could be valuable, especially for those without a strong professional network, as long as individual preferences for specific mentors were taken into account.

If there's something formal, it might be easier for someone, if they were an outlier, to sort of contact that particular person and to know they've got that formalised support there. ... I feel like I've got enough in the way of networking to know, if I was worried, I know the people to go to and say, 'Can you give me a hand with this? I'm having some trouble.' But I think that's not necessarily the case for everyone. ... Sometimes the networks aren't that strong or, typically with some of the overseas-trained doctors who may not necessarily have had the background ... through their training, sort of having to come across a multiple number of bosses here. So I think ... there'd be a role for it in some areas. ... [Q: Would it be better to contact a named person or leave your details and have someone call you?] I suspect probably a named person might be better, just because, ... surgeons being what they are, there are certain ego clashes. ... There's been different mentors around for different companies, and people say, 'Look, I don't want that guy to help me with that particular case,' or whatever. So I think a named one so there's no surprises. (7QRe)

Initiating Mentorship

Several clinicians emphasised that the low-scoring clinician should initiate the relationship, which contributes to minimising any undertones of judgement or punishment. This approach, it was said, is much more likely to be effective than a USANZ-initiated process of scrutiny.

You just put a group of people with specialists or others they can collaborate with and talk to. Anything that has any angle of criticism for an established surgeon is very hard to take. ... Personality wise, it's going to be tough and it's going to be even harder if it's dictated. And if, you know, boundaries are put in place or limits are put in place, it's going to be difficult to police that; they're not going to have the outcome that you're after. ... The idea would be that [a surgeon] could have a database of how they do things. If an operation has like 10 different steps, right, we create a database of how Dr. Such-and-Such does each bit. And then if I know that, okay, maybe I don't do my anastomosis right, I go to this database and I have 10 different ways of 10 different people doing it. ... It's all there. I would access it. You could analyse it and just learn again. That would be an easy, easy way to aid this one problem, but you see how different people do it. And you know, you could contact specific people from the database, get feedback. (5NZM)

Another participant said that, if a surgeon is scoring poorly:

I would hope that surgeon would reflect and then seek counsel. ... I think that it should be the clinician who approaches USANZ or PCOR to say, 'Look, I am out here, two standard deviations. Who can I talk to?' So that's a really important structure, that it's not Big Brother coming to them, it's them seeking us, the mentor, as it were. And, you know, there's a long history of failed mentorship. ... We all struggle with keeping a viable mentorship program going. Whether it's our young trainees or whether it's our colleagues, it's the same thing. It doesn't work unless it's coming from the person who requires help. ... Now that doesn't mean that we don't promote it and we don't make it

there, you know, on every page of the report, saying, 'Look, if you have any concerns, we have people, trusted colleagues within your society, who will talk to you anonymously.' ... Keeping anonymity and security of your information is probably a key. ... You know, it's almost whistle-blower. You're going to whistle-blow on yourself? ... The mentors need to be trained, to have been taught how to mentor, ... how not to be judgemental, and not to be threatening, you know. It's almost a counselling program. Because it will take a lot of intestinal fortitude for a person to reach out, you know, where egos reign supreme, in some circumstances. (2QMRe)

There were practical suggestions about how such a program might work, including the need to take further steps with clinicians who fail to contact a mentor.

[Information about mentors] could be organised sort of as a separate thing on a website or something like that, you know. At the bottom of your report, it says, you know, 'These are your executive summary of your results. And, if you're interested, these are four mentors that are in the top 5% of the national quartile in terms of their results. And they're open to being available to discuss their processes and management and being mentors, if you feel that you want to do that.' And then, obviously, if it's visible that there are still outliers and they're not making that leap of faith in terms of doing that, then potentially, if those people are in a section where they're either dangerous or harmful, then there may be, somewhat, ways of getting more invasive in terms of discussing it with them. (3NZMRe)

This clinician also said that USANZ should be responsible for keeping an eye on poor performers and, if that is not possible, the role should be taken by the College of Surgeons.

In contrast, another participant said that it was important that the low-scoring clinician could not choose the mentor. Mentors must be very carefully selected and the process of mentoring should be based on a comprehensive protocol.

I think it's far more appropriate to have just specified people who are designated. ... In that context, I don't think choice is a good thing. But the mentors need to be selected very carefully, as being, I would say, colleagues of the highest calibre and, I'd say, reputation, not just as surgeons, but probably as people. Let me give you an example. Let's say I turned out to be an outlier. And if I had some colleague contact me who I didn't really have much time for, that wouldn't work very well. And, like any position, I suppose, how you select for that would be interesting. But it would also be very important to do, if you're going to have a handful of people, and it might only be one or two, depending on how many outliers you've got. But I don't know how many people would be considered for that from a USANZ point of view. But yeah, you'd have to have very careful selection. ... That colleague needs to have a formal position. They can't just be a random person. ... They'll need to have a few sort of very strict rules about confidentiality and so on that relates to their role and the fact that those conversations that they have are going nowhere. And I think that's really important because ... conversations do occur outside those strict channels. If, you know, let's say for example, a complication, a bad one, becomes known; well, you know, the gossip machine cranks right up. And I think that's very unfortunate. ... It will be absolutely critical, given that there is that context in the general community, that whatever discussions did occur in this instance, that it was highly regulated and that there would be real consequences for breaching that confidentiality. ... An initial contact could simply be, you know, as per standard, which is an email. But then, I think, it would be very useful, given the sensitivity of the area, for the actual discussion about the reasons that someone might be an outlier should be face-to-face. And when I say face-to-face, I don't mean in the same room necessarily. ... I think that human-to-human is critical. ... It should be, at minimum, a video call. (9VMRu)

Regulation, confidentiality, and a high standard for mentors were common attributes of any mentorship scheme, whatever the direction of mentor-mentee contact.

The possibility of two options for mentoring a clinician with low QI scores was also put forward. The clinician could contact an identified USANZ representative. If this hasn't occurred within a specified time, a USANZ representative would contact the clinician and arrange a meeting to review the last year's case reports.

The problem is that you've got to get the person to be insightful enough to know that they should make the call. That's the tricky one. And I don't think if you left it to people to volunteer that they necessarily would. ... When you send out the report with all the data to all the individual people who you notify, they can look at their performance on the pictogram. You could say, 'Your performance has been identified as an outlier. These are the two options. The first is for you to contact the SAG group. The second is we will be getting in touch with you by a representative from the SAG group.' So you could give someone the opportunity of calling up and saying, 'Yes, I know that I've been identified as an outlier. I don't know why that is.' Because that's what people will say. 'I cannot understand how that could possibly be.' And then the SAG or the representative of the SAG who's in charge would say, 'Okay, well, you can either have a look at your cases and report back to me, or how would you feel about us sending someone out to interview you?' ... And you don't want to throw the baby out with the bath water; ... that means keeping the politics out of it. ... You have to do something about it and you'll be given a certain amount of time to get your thoughts together, get your cases together, and respond. And you might be given another warning, and then you can expect a call from a representative. And who that would be? If you were to make it a leading-light clinician, well, firstly, they probably wouldn't have the time, but that would be intimidating, I think, to a degree. ... You either self-direct or someone's sent. Someone, I don't know who, will seek to clarify why you are an outlier and then the natural next step of all that is counselling. (8QM)

Difficulties In Implementing the Scheme

Practical and ethical difficulties were identified in implementing a mentorship program. Several participants doubted that appropriate senior people would have the time to commit to mentorship. One of them, 8QM, suggested that USANZ leaders would need to be prepared to do so. Others were concerned about governance and responsibility.

These professional colleges ... probably already have conversations from time to time, or history of having a professional colleague who needs to have some guidance or advice. And, you know, there's an organisational problem there, a governance problem of, well, how do you do that? ... How do you provide natural justice and how do you ensure that you protect them and all the rest of that sort of stuff? And so it's quite a difficult problem, I suspect, because you've got a duty to a professional organisation like USANZ to look out for the interests of the patients, but you've also got to balance that with your professional duty to look after the profession. ... I'm sure that the patient should come first, but it would be easy for professional organisations also to be captured by the profession and allow things to occur that shouldn't. (1VM)

One participant thought it might be reasonable to have the telephone number of an approved mentor on each report so that the recipient of the report could choose whether or not to seek peer support, but still thought that the mentorship scheme might be difficult to implement.

If they started to say, 'We have a panel of experts that you can go to, to help with the technique', I think they would struggle to get such a body up and going, and it would struggle to have people come to them, cap in hand, asking for help. Sadly, I think that's the truth of the situation. (4QMRu)

Although a mentorship scheme might work among colleagues or as part of a supportive environment, one problem might be with people who work alone.

I can imagine that there'd be some resistance to outliers if they're not in a supportive environment. ... People who tend to practise on their own tend to be practising on their own because they have issues working with other people. And if they have issues working with other people, then I think they're also probably going to be people that are a bit resistant to being made to be mentored. ... It will come down to the individual. Do they want to improve or not? ... Australia's been sort of plagued by this concept of financial toxicity around this operation. ... And there's no evidence that the people charging enormous sums, for the large part, are any better or worse than anyone else, because they haven't presented their data. Some of them do, and I think if they do, well, fair enough, you know. But a lot of them don't; they've just leveraged off the pricing of the ones that do. And are those people who are saying that they're brilliant, if they're not brilliant, going to, in any way, acknowledge that? I would doubt it. ... At the end of the day, the only way I think that you can drive this sort of behaviour is financially. If your reimbursement is part of being party to these programs, then you will contribute to them. But if you make these programs, in a way, at least perceptually punitive, then I think people would stop contributing. So if you're a high-fee surgeon in an environment like Sydney, where you're saying you're really good, the data comes saying you're not, and it's voluntary, then I would imagine that most people would just stop contributing the data. (6NZMRu)

The threat of having surgeons withdraw or refuse to contribute their data if they felt under pressure or scrutiny was a thread throughout the interviews.

Who Should Manage the Mentorship Scheme?

Although the mentorship scheme was proposed as a USANZ initiative, not everyone agreed. Two participants argued that any approach should be made by the PCOR; it should not be USANZ's role to organise mentoring (10VM, 12VMRe). USANZ could work with PCOR to devise a list of experienced practitioners who could serve as mentors. Any mentorship must be conducted within legally binding confidentiality parameters (12VMRe).

I think ... it needs to be a PCOR, a Monash University PCOR community. I don't think it should be USANZ community. I think USANZ can partner and have, let's say two, three, four, five urologists per state that could act as mentors for underperforming surgeons if they choose to do that. And because I don't even think people can tell USANZ that someone's underperforming because that would be a break of confidentiality. I think those people ought to be strongly encouraged to approach USANZ and USANZ will actually provide some support. I think they need to be aware that USANZ will not be told by PCOR; it's up to them voluntarily, whether they want to seek some extra assistance or not. ... USANZ could then, in a sense, have a group of urologists who have agreed to act as radical prostatectomy mentors for people. And then PCOR could simply offer those people who are underperforming to say, 'USANZ has a number of people who are happy to mentor underperforming. If you would like to take advantage of that, you can get hold of USANZ.' ... And this goes back again to the whole, you know, qualified privilege versus, like, how do you manage the legal consequences of that so you don't get bitten by it? Because the biggest complaint that a lot of urologists will have is that they'll say, 'Well, you just ... want to muck up my career so that you can get potentially more cases.' So ... there needs to be a, you know, a legally appropriate way of doing this. (12VMRe)

One participant suggested offering continuing education rather than targeting surgeons with low scores.

[There could be] refresher courses, hands-on education components that would work. That would be non-inflammatory. But I think if they started to say, 'We have a panel of

experts that you can go to, to help with the technique', I think they would struggle to get such a body up and going, and they would struggle to have people come to them, cap in hand, asking for help. Sadly, I think that's the truth of the situation. (4QMRu)

Finally, there was one vehement argument that mentorship is pointless because outliers blame everyone else for their position. Furthermore, it places an unreasonable burden on a mentor to be required certify that a poor performer has reached the required standard.

I'm not sure that urologists who already feel defensive would like to be, you know, brought to other people's attention and have it well known that they need help with that procedure. So I guess it would have to be done delicately. And secondly, ... there's no way I'd want to be mentoring someone. And for how long? And how are you measuring outcomes? USANZ did this with the nephrectomy data. So when it became apparent that there were some very bad outcomes with deaths and major complications from nephrectomy being performed by surgeons who weren't adequately trained, USANZ had this great idea that they'd run a course. And so the surgeons who were having bad outcomes could do a week course and try to upskill them. And it's such a token effort because what can you achieve in a week? ... And now you're suddenly pinning the responsibility on USANZ, who would then want to give them a certificate? So now they're not going to kill people? I don't know. ... If you're going to have that sort of program, it would have to be over a significant amount of time, a certain number of cases. It would have to involve re-skilling, where training that surgeon would have to commit to watching cases, attending other surgeons' lists. I'm not sure you get buy-in from people who were going to say, 'Well, the data's bullshit and for these reasons it's not correct.' And I don't think USANZ could mandate that. They don't even have any regulation where they can dictate which surgeons do which procedures. So I don't think they have way of actually enforcing them. So yeah, it looks nice on paper, I guess is my point, but I can't see how that would work in practice. ... I wouldn't really want to be the one taking responsibility for them; mentoring someone and then signing them off to saying, 'Yep, now they're all fixed.' ... Even if you have a mentorship program, they've got to turn up and attend. So yes, they do need to take responsibility, first and foremost. (11VM)

HOW TO IMPROVE REPORTS

Despite general support for the reports, there were a few questions and problems raised during the interviews. Even participants who could not offer specific recommendations were open to the possibility of improving them.

I think that the data presentation is pretty reasonable, actually. Having said that, you know, I'm sure there's always room for improvement. I must say, off the top of my head, I can't think of some quick way of improving them. I do take a little bit of time just to sort of get your head around the graphs and so on, but, you know, eventually it's pretty straightforward. (9VMRu)

Participants suggested ways in which the reports could be improved. For example, a clinician who had received only one report found the bar charts difficult to interpret (5NZM). He also said that important information is not recorded; this included whether a registrar did a large fraction of the operation for training. Furthermore, in New Zealand, his Pacific Island patients have distinct anatomy and body habitus that render surgery potentially more difficult and risky. He asked whether information about ethnic origin or country of birth is collected and taken into account. Finally, he expressed concern that the PROMS packs may not be available in all the languages spoken by people in New Zealand, nor might they cater for patients with limited literacy who may therefore not complete them. Other clinicians also thought that it would be useful to record and take account of patient characteristics such as impairments and BMI (for example 7QRe).

The way in which we aggregate groups, or the way in which we choose people over the time, or the way that we calculate statistics, I think, you know, all those things could be

improved. ... At the moment I think it's insufficiently systematic, and it would be better if we could envisage and build a system that works around it that helps them have an effect. And, you know, it's a costly and time-consuming thing to do that. ... So we're doing some good at the moment and we shouldn't let the best get in the way of the good. (1VM)

It was also suggested that the recorded fields could be rationalised.

I think it would be fair to say that not all the fields that are there are as valuable as others. ... I've never found that recording the clinical T stage in the notes is as critical. I mean, virtually 95% of them are clinical T1Cs. And, you know, the reality is that I don't view that that's really a quality indicator, whether or not you've actually recorded that, or not. I mean it doesn't mean that you haven't worked the patients up properly. ... The percentage of low risk patients who are getting active surveillance or were having treatment: I think that's a particularly valuable indicator. I think the continence and potency outcomes are very critical indicators. And the pathologic T2 positive margins I think are a critical indicator. ... I'd really love to see, which isn't in there, the rates of second treatment. So, for example, if you've had surgery and then have needed radiation afterwards or needed hormones afterwards, looking at your rate might, I think, compared to your peers, would be quite valuable. The positive margins for the sort of low risk versus intermediate risk versus high risk: They're good to have there, but I don't think that they're as critical as the PT2 margins from a quality point of view. I think that they're interesting, but there are surgeons who spend most of their time operating on pretty aggressive cancers. So you're going to end up with higher numbers of positive margins, and it's got to do with case selection rather than clinician skill. But a PT2 margin rate is important because that's probably the best indicator of—because if it is truly organ-confined, most people are going to get clean margins, or they should. And so I think that that's valuable as well. ... There's always a big deal at the time when we're trying to get out the information to clinicians, what you've got to include and what we're going to include in annual reports and all the rest of it. I think, what can we get in an annual report, for example, I think can be a bit different, but I think what clinicians want to get are those key things that actually are metrics as to their performance. And I think it's: Are they operating on too many low risk patients? What are their positive margin rates like compared to their peers? And are their organ-confined, you know, margin-negative rates reasonable? ... That's probably going to be the best option, you know, so I just think that there's more in the reports than there needs to be from a clinician point of view. (12VMRe)

It was pointed out that there is a fine line between having enough and too much data.

It comes down to this balance, doesn't it, of how much data you collect and how you interpret it because, you know, if you start getting too much data, the registry becomes cumbersome and unmanageable. (2QMRe)

Although most of the participants themselves found the reports straightforward and readable, a few acknowledged that others might encounter difficulties.

People may not be familiar with funnel plots and other things. ... On the other hand, I personally think that they're very well presented and, as they still do in every report, there is opening sections to say, 'How do you interpret this and that?' You know, so I think already there's been a bit of work done by the team that helps understand the data. ... Most of us prefer to have more data rather than less data and skip through it. ... Maybe that's the conversation with USANZ, to say ... that there's some confusion with the reports. And in fact, I think it would be really good to say, 'What your PCOR report is telling you.' (10VM)

The view was also expressed that recent changes, including presenting data in a new way, had not improved the reports.

I think that data's important. I think the way it's currently being presented, it's probably not as clear as it could be. And personally, in some ways I'd like to almost go back to the way it was. Because I thought it was easier. ... As a user, I actually find it more difficult. I think the new formats are not easy to follow. Personally I think the forest plots actually are easier in a lot of ways where you've got your median, and you've got your standard deviations one and two above; you've got the dots everywhere, and you've got your dot in red. And I actually thought that was actually relatively easy. (12VMRe)

Because the reports are constructed and written by algorithms it is impossible to take into account all individual circumstances. One participant suggested that the algorithm should be assessed and amended from time to time to incorporate what has been learned about important influences on outcomes and to ensure that reports are targeted (1VM).

[Reports are] mass produced. ... There's a lot of work involved in producing because they're individualised for clinicians who contribute. And they're individualised or summarised for health services and perhaps in Victoria for integrated care services. ... Hundreds of them are done, ... all maybe let's say 20, 30 pages long, with quite a lot of texts and graphs in them. And they're done twice a year. So when you start to think about that, it's a big job. ... It's all automatically generated, but the implications are that each individual report [is checked] by the database manager. ... She or he doesn't read 200 reports and make sure that every single word is right. ... There's a certain inertia to the algorithms that you use; ... it's not like I'm adjusting the temperature on the thermostat. ... If you make a change in the code that affects everyone you've got to be careful that there's not some bug that, you know, makes someone look terrible somewhere. ... There's so many things that, you know, would have an influence on this. And one of the things about it is that some of them are not reasonably under the control of the people who get the reports. And so you have to think about targeting the reports and the information to people that can have an influence on parts of the whole system. (1VM)

Maintaining anonymity was seen to be important; this necessitates restricting the basis of comparisons, which should remain national. "It's important ... not to do it [make comparisons] state by state, because there are some small states which automatically means you can by default start identifying practices" (2QMRe).

One person thought it might be a good idea to invite feedback on the reports ((2QMRe).

ADDITIONAL COMMENTS

A few cross-country comparisons were made. For example, New Zealand participants commented on the monetary incentives in Australia that do not apply in New Zealand and that, one suggested, might make it hard for high-fee surgeons to admit to anyone, including a mentor, that they were outliers. Manipulating funding might contribute to improved outcomes.

I think a lot of those behaviours will be driven eventually by funders, whether they be state or private. And the reason is that there is now a drift at last towards outcome funding. [In New Zealand] we have the ACC [Accident Compensation Corporation], which covers a lot of accidental injuries. And they are now starting to fund packages of care, looking at outcome rather than looking at discrete procedures. ... I know that our private providers are interested in that. ... It just makes sense that actually you pay for an outcome, not for the fact that someone's done a procedure, because the indications for procedure might not be good. The outcomes might not be good, so why would you fund that? (6NZMRu)

One participant summed up the complex circumstances succinctly:

I think this, you know, all this quality and safety stuff, no matter what the specialty, and it's all got to be very paramount for a government in the future to make, because at the end of the day, as, if you were a consumer instead of the doctor, you'd want to have some transparency of understanding outcomes. But the problem then is that the, you know, the government is going to want that, but then what'll end up happening, if I was a consumer and I saw, well, actually, you know, Dr Smith does much better than Dr Jones. So everybody will want to go to Dr Smith and Dr Jones will never get the opportunity to get better because no one will go to them. ... That's why I've always felt that this stuff should, it needs to be fed back to clinicians. I think there needs to be a clinician panel overseeing the data. I've never been a huge fan of publicly, really, stating it, for that reason, because at the end of the day, the good experienced surgeons will continue to be good experienced surgeons, but eventually they'll retire and then you've got to deal with less skilled doing the surgery. (12VMRe)

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APPENDICES

APPENDIX A: LETTER OF INVITATION



UROLOGICAL SOCIETY
OF AUSTRALIA
AND NEW ZEALAND

Dear member,

PCOR-ANZ Quality Indicator Report

Recently PCOR-ANZ has developed a National Quality Indicator Report to be sent to participating hospitals and urologist. These reports provide results on a core set of indicators developed by clinicians and researchers. USANZ supports the PCOR-ANZ effort to improve quality of care and endorses participation by its members.

As these reports are being developed, USANZ is keen to engage with clinicians to understand their views on the reports, in particular as they concern 'outliers', and to help to ensure that they are addressing the needs of its members. We are keen to understand how these reports might, or might not, inform your practice. We also hope to learn clinicians' views on a targeted mentor program. To these ends, we are inviting our members to participate in a phone interview to better understand any concerns or suggestions you may have. We would also encourage correspondence via email or letter if you would prefer this approach.

We are actively seeking urologists from across Australia and New Zealand to participate in this study. Many of you will have received reports before, but for many, these reports will be new and unfamiliar. We welcome those who do and do not contribute to the registry and those who do, and do not, currently receive reports. Interviews and analysis will be conducted by experienced researchers who are not urologists; all interviews will be confidential.

If you would like to participate in the interview (approximately 30 mins) or to learn more about what is involved, please email Dr Maggie Kirkman (maggie.kirkman@monash.edu) from Monash University. After the interview, a small honorarium will be provided to compensate for your time.

Yours sincerely

Stephen Mark
President

Urological Society of Australia and New Zealand

APPENDIX B: INTERVIEW GUIDE

INTERVIEW GUIDE FOR UROLOGISTS

1

- Thank for volunteering.
- Check that time is still convenient.
- Any questions before continuing?
- Permission to record (to ensure accuracy)?
- [If consent form not returned] Seek formal consent for participation, to be recorded.

As you know from the information we sent to you, we're wanting to learn from clinicians how to improve reporting from the Prostate Cancer Outcome Registry. We're speaking to clinicians who don't contribute to the registry as well as to those who do. USANZ has proposed an approach of education and support and of working with contributing clinicians, and we're also seeking views on that approach. I'm working with another researcher (Professor Jane Fisher/Dr Maggie Kirkman) on this project; neither of us is a urologist nor are we part of the registry. Everything you say is confidential. If we quote you in a report or journal article, we will take great care to ensure that you can't be identified.

PROSTATE CANCER OUTCOME REGISTRY

I'd like to start by asking you about the Prostate Cancer Outcome Registry. What is your experience with the registry?

PROMPTS *if necessary*:

- Have you been asked to join the Registry?
- Do you contribute data to the registry?
 - [IF YES]
 - Why did you decide to participate in the registry?
 - For how long have you been contributing?
 - [IF NO]
 - Can you tell me about why you chose not to contribute to the registry?
 - What might lead you to change your mind?

QUALITY INDICATOR REPORTS

As you know, the prostate cancer outcome registry produces Quality Indicator Reports. We're very interested to hear your views on these reports.

PROMPTS *if necessary*:

- Do you receive the reports?
 - [IF YES]
 - What are your views on the reports you've received?
 - [IF NO]
 - We included a copy of the report in the information we sent to you. What are your impressions of the report?
 - What does the report show you?
- What do you hear other urologists say about the reports?

ACTING ON INFORMATION IN REPORTS

It would be very useful to know whether the reports have any effects, and what can be done to make them as helpful as possible.

Can you comment on their usefulness and effectiveness, please?

PROMPTS *as necessary*:

- What do you think it means when a report indicates that someone appears to have much *higher* quality scores than others?
- What do you think it means when a report indicates that someone appears to have much *lower* quality scores than others?
 - Prompt, if necessary: Please consider factors that might be outside a clinician's control.

INTERVIEW GUIDE FOR UROLOGISTS

2

- Statistically, a trigger is flagged when a clinician's results on a quality indicator fall below the limit, which is set at two standard deviations below the mean. At what point do you think a clinician should be concerned that there could be a problem needing further attention?
- What, ideally, *should* a clinician do if their results were not as good as they'd like them to be?
- What do you think that clinicians *would usually* do in these circumstances?
- What do you think would be most helpful and useful to a clinician whose results were reported as being at the low end of the scale?
- What do you think USANZ could do that would benefit a clinician whose results were at the low end of the scale?
- What other things, processes, interactions, or communications about these six-monthly reports might improve the impact, understandability, or effectiveness of the registry?
- Can you suggest a term that could be used for clinicians whose results fall two standard deviations below the mean? [If necessary: 'Outlier' is one term that's been used.]

If you were managing the registry, what would you like to test, or implement, or trial with the reports?

PROPOSED USANZ MENTORSHIP PROGRAM

USANZ is proposing to establish a mentorship program, which would be voluntary and confidential. The plan is that a telephone number for USANZ's approved mentor support would be listed on the Quality Indicators Report. Urologists could choose to call it for confidential peer support or mentorship.

What are your thoughts on such a mentorship program?

PROMPTS *if necessary*:

- Should USANZ provide a mentorship program in response to PCOR-ANZ Quality Indicator Reports?
 - Would you consider using such a program? [Can you explain why/why not?]

Have you had experience with a professional mentorship program?

If yes: In what ways was it useful to you?

How could it have been improved?

DEMOGRAPHIC DATA

We'd like to be able to summarise some characteristics of the clinicians we've interviewed, such as average years of practice as a urologist, so I hope you're willing to answer a few final questions.

[NB DON'T ASK ABOUT WHAT IS KNOWN FROM THE INTERVIEW OR INFORMATION GIVEN PREVIOUSLY, although might be appropriate to confirm it. In these circumstances, insert information below for the summary.]

- Where do you practise?
 - New Zealand/state in Australia
 - Metropolitan Rural Regional Other
- For how many years have you practised as a urologist?
- Do you contribute to the Prostate Cancer Outcome Registry?
- Do you receive Quality Indicator Reports from PCOR-ANZ?

CONCLUDING COMMENTS

We have no more questions.

Is there anything you would like to add about the Quality Indicator Reports?

Thank for their valuable contribution.

Request a copy of the report? If so: email address.

Our report will be sent to USANZ and the Prostate Cancer Registry Steering Committee, where next steps will be discussed.

Any questions for me or one of the Investigators on this grant?

Where to send the \$100 honorarium for participation?

APPENDIX C: PARTICIPANT EXPLANATORY STATEMENT AND CONSENT FORM



UROLOGICAL SOCIETY
OF AUSTRALIA
AND NEW ZEALAND

EXPLANATORY STATEMENT

PROJECT: Clinician-level Quality Indicator Reports: A qualitative research project to understand views of clinicians receiving and not receiving these reports

INVESTIGATORS:

Dr Maggie Kirkman
School of Public Health and
Preventive Medicine
Monash University
553 St Kilda Road
Melbourne
Australia 3004
[+613] 9903 0295
Maggie.kirkman@monash.edu

Prof Sue Evans
[+613] 9514 6216
sue.evans@monash.edu

Prof Peter Heathcote
[+617] 38303310
pheathcote@brisbaneurologyclinic.com.au

Prof Jane Fisher
[+613] 9903 0290
Jane.fisher@monash.edu

Prof Jeremy Millar
[+613] 9076 2167
Jeremy.millar@monash.edu

Mr Stephen Mark
0064274355547 (NZ)
stephen@urology.co.nz

Prof David Currow
[+612] 8347 5601
david.currow@cancerinstitute.org.au

Prof Mark Frydenberg
[+613] 8506 3666
frydenberg@optusnet.com.au

Prof Mohamed Khadra
[+ 612] 4734 2608
khadra@urology.net.au

You are invited to take part in research on urologists' opinions of the Quality Indicator Reports distributed by the Prostate Cancer Outcome Registry—Australia and New Zealand (PCOR-ANZ). If you would like further information about any aspect of this project, you are encouraged to contact the investigators using the phone numbers or email addresses listed above.

What is the purpose of this research project?

The aim of this research is to learn how urologists respond to reports of the quality of care, how potential 'outlier' activity could be best be communicated and managed, and the utility of a mentor program proposed by USANZ.

Why were you selected for this research?

You are a member of USANZ, working in New Zealand or Australian, who treats men with prostate cancer. You have received this information because you have responded to an invitation sent to you by the president of USANZ.

What does the research involve?

If you agree to participate, you will be interviewed (for up to 30 minutes, depending on what you have to say) by Dr Maggie Kirkman or Professor Jane Fisher of Monash University. Neither interviewer is a urologist. The interview will be by telephone at a time convenient to you. The interview will be audio-recorded to ensure accuracy but will not be heard by anyone other than the interviewer and a confidential transcriber.

Consenting to participate in the project and withdrawing from the research

Participation in this research is voluntary. If you do consent to participate, you may withdraw from the study without explanation until the audio recording has been transcribed, which will be about a week after the interview.

Possible benefits to participants

Contributing your insights to improving the work of USANZ and PCOR-ANZ will benefit the profession but may not benefit you personally.

Possible risks to participants

We do not foresee any risks as a result of participation in this research, although we acknowledge the contribution of time and potential inconvenience.

Recognition

We are offering a \$100 gift card in recognition of time away from clinical practice.

Confidentiality and storage of the data

As soon as possible after each interview, the audio recording will be transferred from the digital recording device to a secure password-protected file on the Monash system, accessible only to the interviewers. Your interview will be treated in confidence. The recording will be transcribed using a secure, well-established system. Your name and other identifying details will be disguised or deleted on the transcript. The anonymised transcript will be kept in a password-protected file, with access limited to the researchers. Names and contact details will be kept in a secure electronic file separate from other data, used only to arrange interviews and seek any necessary clarifications. We will not use your name or other identifying details in any publications, reports, or talk about the research. In accordance with Monash University protocols, all research data will be destroyed 7 years after results are published. If you would like to see your anonymised transcript before analysis is complete, please contact Dr Maggie Kirkman within two weeks of your interview.

Results

Results of the study will be presented in a report to USANZ and the funder, Movember. It is possible that a peer-reviewed publication and conference presentations may also arise from the research. The results will be available on the USANZ website, possibly in mid-2020.

Complaints

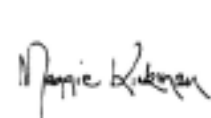
Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics Committee (MUHREC):

Executive Officer

Monash University Human Research Ethics Committee (MUHREC)
Room 111, Building 3e
Research Office
Monash University VIC 3800

Tel: +61 3 9905 2052 muhrec@monash.edu Fax: +61 3 9905 3831

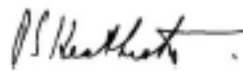
Thank you for your interest,



Dr Maggie Kirkman



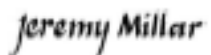
Prof Sue Evans



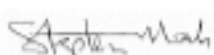
Prof Peter Heathcote



Professor Jane Fisher



Prof Jeremy Millar



Mr Stephen Mark



Prof David Currow



Prof Mark Frydenberg



Prof Mohamed Khadra



UROLOGICAL SOCIETY
OF AUSTRALIA
AND NEW ZEALAND

CONSENT FORM

PROJECT: Clinician-level Quality Indicator Reports: A qualitative research project to understand views of clinicians receiving and not receiving these reports

INVESTIGATORS: Dr Maggie Kirkman
Prof Sue Evans
Prof Peter Heathcote
Prof Jane Fisher
Prof Jeremy Millar
Mr Stephen Mark
Prof David Currow
Prof Mark Frydenberg
Prof Mohamed Khadra

I have been asked to take part in the Monash University research project specified above.

Signing this consent form is evidence that I:

- Understand the explanatory statement
- Consent to take part in the research project
- Consent to be involved in the procedures described (an audio-recorded interview)
- Consent to the use of my personal information as described

I understand that participation in this project is voluntary and that I am free to withdraw before, during, or up to two weeks after the interview. I understand that I have the option of viewing my interview transcript and that none of the data I contribute will be published in a form that could identify me.

I hereby consent to participate in this project.

Name of Participant _____

Participant's Signature _____

Date _____

