Registry Participation is Our Professional Responsibility

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In 1986 the New York Times ran a front-page story that the Healthcare Financing Administration, which in 2001 was renamed the Centers for Medicare and Medicaid Services, would release the names of hospitals that have mortality rates higher than the national average for coronary artery bypass surgery (CABG). In response to this report and out of concern that administrative data is insufficient to measure the quality of care several cardiac surgery registries were developed including the New York State Cardiac Surgery Reporting System (CSRS), the Northern New England Cardiovascular Disease Study Group (NNE), and the Society of Thoracic Surgeons (STS) National Database. Since the late 80s participation in regional and national registries has grown and today would be considered standard practice.

Shortly after implementation the CSRS and NNE began reporting a reduction in mortality rates for CABG surgery. The strategies were different but the efforts to collect and report data motivated quality improvement efforts and by 1992 New York State and Northern New England had the lowest mortality rates in the country for CABG surgery.

We have enjoyed a steady decline in mortality rates for CABG over the last 25 years and our focus has shifted to minimizing morbidity after cardiac surgery. In order to better understand the association between cardiopulmonary bypass (CPB) and morbidity we need more context regarding the management of CPB. To that end the NNE developed their Perfusion Registry, AmSECT and now the Michigan State Quality Collaborative developed the PERForm Registry, in Australia and New Zealand they developed the Australian New Zealand Collaborative Perfusion Registry, and the Japanese developed their National Perfusion Registry.

Since their inception these registries and others like them have contributed significantly in three important areas:

- Guiding quality/process improvement work
- Generating new knowledge
- Benchmarking

Participation in a clinical registry is our professional responsibility. Registries allow data to be collected across diverse patient populations and in much higher volume than any single center can achieve on their own. Multi-center data can then be used to generate new knowledge regarding the association between the management of CPB and patient outcome. In addition, registries allow us to benchmark our practice against our colleagues and highlight opportunities for process improvement. Contrary to some perceptions, the collection of data is not as timely as some may claim. Our Japanese colleagues report their data form, which is similar to the NNE and PERForm data forms, take an average of 15 minutes to complete.
Perfusionists should consider participation in a registry no different than our responsibility to set-up, prime, manage, and break down the heart/lung machine.

References: