In-sight
By Dr Jeremy Lim, Editorial Board Member

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MRSA Infections in Singapore – Public Reporting to What End?

The Straits Times’ headline screamed “800 were hit by superbug in Singapore hospitals” but I was left wondering what the Ministry of Health (MOH) was hoping to achieve with the latest information paper on “Hospital Acquired MRSA Infections in Singapore” released on 16 November 2007.

Let me explain. In general, public reporting of hospital data is intended to either educate patients as consumers and allow market forces to work better, or motivate provider hospitals to improve the quality of care delivered. Evidence on the former is sparse with the available data generally suggesting that few patients understand the results, let alone know how to use the reports available in any meaningful way. RAND Health in a 2000 monograph Dying to Know: Public Release of Information about Quality of Health Care dryly summarised: “… consumers and purchasers rarely use them.” The data on the impact of public reporting on healthcare providers is a little more encouraging, and at least one well-controlled randomised trial in Wisconsin published in Health Affairs four years ago concluded that public reporting “appears to stimulate quality improvement activities in areas where performance is reported to be low.” In Singapore, Minister for Health Khaw Boon Wan has gone on record at least twice attributing the dramatic drop in price for LASIK surgery to public reporting of prices.

With this perspective on why public reporting is undertaken, let us evaluate the MRSA infection paper:

Helping patients make better choices. I asked lay friends what they thought of the information paper as reported in the media and the universal response was “So what?” Upon further thought, one intimated that he was actually not sure what MOH was trying to communicate and how he as a member of the public was supposed to react. I was not surprised that The Straits Times’ account of the report highlighted the lack of information on the number of deaths attributable to MRSA infection (available incidentally for both the US and the UK), the increased length of stay for infected patients and whether patients in different ward classes were equally at risk, all arguably information the public would find useful to better understand the implications of MRSA infection.

Stimulating healthcare providers to improve. The MOH did not risk adjust and instead qualified the crude rates presented with the statement “The differing rates may be a reflection of the different casemix between the hospitals”. This was particularly puzzling given that the same United States’ CDC National Nosocomial
are now better businesses to invest in. However, if the reason was to alleviate suffering, then nothing has changed. There is still an enormous amount of suffering that needs alleviating.

OJJ: I was very amused by a quote about the Emergency Department from your book “...a huge red cross in neon lights: “We are open. Come to us with your injuries and illnesses, your excesses and your stupidities. We will do our best to heal you and get you back to your drinking and smoking next week.” It sounds as if you have worked in the trenches too! If this is true, how did you find that experience?

MK: Emergency is exciting. You do not know who is coming in next. The 18-year-old boy who has destroyed his life so that he can impress his friends by driving fast. The 90-year-old lady who is tired of living but who is resuscitated anyway. The violent drunkard, the violent ICE addict. Single events that radically alter a human being’s future. It is exhilarating to work in this environment. However, it also takes away your faith in human beings.

OJJ: You talked about why you gave up surgery. Would you say that being an effective surgeon requires one to be detached and gung-ho to some extent? Is that necessarily a bad thing?

MK: I believe surgeons have a huge responsibility placed on them. On the one hand, they need to be totally detached and objective so that they have the courage to place a clamp across an artery without fear. On the other hand, when the patient is awake, they need to be communicative, compassionate and make human connection.

OJJ: How has your perspective on life changed since your battle with cancer? Have you taken up any new pastimes or drawn up a to-do list?

MK: I try to make each day the best it can be. Confucius says: “When you sweep, sweep!” So I try to live each moment full of joy. It is great to be alive.

OJJ: Are you already drafting your next book?

MK: No, not yet. I have thoughts about a book about migration.

OJJ: What advice would you give to other doctors, based on your own wealth of experience?

MK: I would say that the most important thing is align our expectations with the patient’s expectations. A good surgeon knows when to operate; a great surgeon knows when not to operate.

OJJ: Thank you for your valuable time.

Taking a broader perspective, I worry that the decision to not risk adjust, which is so fundamental when dealing with complex medical conditions, will undermine the Ministry’s efforts to persuade healthcare providers, including family physicians, to report clinical outcomes data centrally. Anecdotally, it appeared one of the concerns over data submission for the Medisave Chronic Disease Management Programme was over how the data would be used in public reporting. This information paper on MRSA is not encouraging.

I must confess that I was rather disappointed with the handling of the MRSA data. I am intuitively inclined towards public reporting to drive improvement and/or educate the public as consumers. In this instance, the absence of risk adjustment and clear explanation of the significance of the findings in terms the lay public can understand leave me doubtful as to what this latest report will actually achieve.