

LETTERS TO THE EDIT

1 Pennington Street, London E1 9XN Telephone 071-782 5000

Drawbacks of league tables for hospital operations

From Mr Nigel H. Harris

Sir, Margot Norman ("How to pick a hospital and stay alive", April 29) fails to mention one of the most valuable parts of the Royal College of Surgeons' national enquiry into peri-operative deaths (1992), namely the detailed breakdown of causation, which were not included in the *Times* published league tables (reports, April 27, 28; leading article, April 28; letters, April 30). Would she not agree that the cause of death is relevant?

Failure to mention doctors' names in the report does not invalidate the statistics. Co-operation of surgeons and anaesthetists is essential for the production of this and future reports. It would not be forthcoming, for obvious legal reasons, unless anonymity was preserved.

Patients who die after operations have not necessarily been "damaged" by the surgical team. Many die from natural causes such as cerebro-vascular accidents, coronary thrombosis and cancer.

Yours faithfully,
N. H. HARRIS,
72 Harley Street, W1.
May 1.

From Mr Charles D. Collins

Sir, Consultants are often blamed for shortcomings in the quality of service that they offer. Consultant surgeons have tried to cope with the ever-increasing workload demands by working harder and longer themselves, pressurising their trainee surgeons to increased service activity, taking on clinical assistants or employing staff grade or associate specialist help. There has been very slow expansion in consultant numbers.

Some surgeons have been able to maintain standards by personal commitment far in excess of that reflected by their contracts of employment; others have compromised the quality of care that they have offered, and most have allowed or encouraged clinical service work to be undertaken by others who may or may not be adequately trained and supervised.

This is the present state of affairs in the delivery of general surgical services and does not measure up to the expectations or requirements of the individual patient, the public, the referring practitioners, the purchasers or the press. Likewise, the quality of surgical practice does not measure up to the standards or rights of the

patient to be reduced it is necessary to gain some understanding of what a general surgeon does and how much he can do. The Royal College of Surgeons of England and the Association of Surgeons of Great Britain and Ireland have concluded that there should be one consultant general surgeon per 30,000 population. This compares with one for 50,000 in England and Wales, one for 32,000 in Scotland and one for 28,000 in Northern Ireland.

Yours faithfully,
CHARLES COLLINS
(Consultant general surgeon),
Taunton and Somerset Hospital,
Musgrove Park, Taunton, Somerset.
May 1.

From Sir Anthony Alment

Sir, It is right to collect and reasonable to publish in useful and significant form performance data for comparable incidents of health care. For many years past the studies of maternal mortality and perinatal mortality and morbidity have been examples of comprehensive confidential surveys beneficial to all concerned, and their degree of confidentiality has ensured that both the detail of enquiry and the confidence of the contributors has been as great as possible.

This government sets great store by the contribution of private health care to the total and it is estimated that about 60 per cent of NHS consultants in Britain have some private practice, with rapidly increasing specialists' earning power over the past 15 years. Yet a recent national survey of independent hospitals with operating theatres, in which details of procedures were sought during just a single week in February 1992, yielded a response rate from them of only 49 per cent.

Should not the use of a standard data set now be a condition for licensing all institutions where patients are cared for? Is it sufficient that the principle of *caveat emptor* and the advertising power of the insurers should be the only common guarantors of quality in the private sector?

Yours truly,
ANTHONY ALMENT,
Winston House,
Boughton, Northampton.
April 28.

From Dr I. C. McManus

Sir, Differences between hospitals in

evidence that hospitals differ in the quality of their care.

Consider 100 hospitals, each of which performs a particular operation with a 1 per cent mortality rate 500 times a year involving 50,000 patients overall. Assume that the quality of hospitals is identical in every respect. Despite that, and inevitably due to the sampling of relatively small numbers, 20 of the hospitals will have either one death or none at all, while another 20 hospitals will have nine or more deaths — seemingly a nine-fold difference in performance.

Variation due to statistical sampling must always exist, whenever league tables are produced. Indeed, one should be deeply suspicious when such variation does *not* occur. But such differences do not prove the existence of *true* variation in performance; for that, more sophisticated analyses are necessary.

What is clear is that if league tables are to be a regular feature of daily life, then professionals and the lay public will require more education in the interpretation of statistical data. And newspapers such as your own will have to learn to present sufficient data for a proper interpretation, including, most crucially, the sample sizes and rates of events.

Yours,
I. C. McMANUS,
Department of Psychology,
St Mary's Hospital Medical School,
Norfolk Place, W2.
April 27.

From Mr J. K. Morland

Sir, Mr M. L. Abel (letter, April 30) is right to draw attention to the importance of compiling accurate statistics of hospital deaths.

Most private hospitals are not geared up for serious emergencies. In my own case as a high-risk patient with heart problems, my consultant refused to perform an operation on me other than in an NHS hospital where full emergency facilities were available. All NHS expenses were reimbursed by my private health insurance. As I did not die, I did not affect the statistics.

On the other hand, a friend, admitted to a private hospital for an operation, developed serious complications. He was transferred to the nearest NHS hospital, where he died one week later.

Yours faithfully,
J. K. MORLAND.