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of advice and support, but effective communication between general practitioners and occupational doctors is unfortunately uncommon. A number of interventions to change workplace factors that have been shown to reduce psychological ill health include counselling, training to manage stress, cognitive behavioural therapy, and workplace support programmes.

The medical profession is under ever increasing public scrutiny, and levels of accountability continue to rise. However, statistics from the UK national workplace bullying advice line show that 20% of cases are from the education sector, 12% from health care, 10% from social services, and 6-8% from the voluntary sector. We need to set our own house in order and should all be striving to foster working environments free of bullies, whether in our hospitals, practices, professional organisations, or colleges.

Those of us involved in teaching medical students and registrars should be mindful of the powerful effects of role modelling on impressionable learners. The authors of a survey of medical students in the United States, along with others, believe that the use of aversive methods to make students learn to behave is likely to foster insensitive and punitive behaviours that are passed down from the teacher to learner, a transgenerational legacy that leads to future mistreatment of others by those who themselves have been mistreated. This undesirable result is compounded when these behaviours are adopted and directed towards patients and colleagues. If we are to avoid perpetuating the harrowing experiences of bullying recently described in the BMJ by a surgical trainee in the NHS, we need to lead by example.

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12 Bullying in medicine. BMJ 2001;323:1311.
Thirdly, there is the question of primary diagnosis. Diagnostic criteria change, as illustrated by the 58% increase in the incidence of myocardial infarctions as a result of using new, troponin based investigations.1 As the additional patients have worse outcomes, there is an incentive for hospitals not to invest in the new diagnostic protocols.

Fourthly, even if the data were accurate, what value would they add to our understanding of hospital performance? A hospital may have a high inpatient mortality rate because of factors related to circumstances before or during admission, to care provided during the stay itself, or to arrangements for discharge. In Scotland, inpatient mortality rates from myocardial infarction are influenced by the extent to which people die before reaching hospital.2 There are large variations in admission rates for many common conditions, not explained by differences in prevalence of disease,3 but which seem to reflect differences in admission thresholds, and thus in severity. Ideally, Dr Foster should adjust for severity and comorbidity, perhaps using secondary diagnoses; although the variable quality of recording in the UK makes that impossible at present,4 adjustment for deprivation could be made. Hospitals also differ in the availability of places for people to be discharged to, such as nursing homes or hospices. Hospital death rates will be higher where these are less available.5

Assuming that the figures are an effective measure of overall hospital performance, what action should then follow? Hospitals are complex systems that are part of larger systems and also contain subsystems.6 Where does a suspected failure lie and who should be called to account? Might failures in one system within the hospital be missed because they are compensated for by good performance in another? Then there is the matter of timeliness, with data relating to events up to three years previously. Finally, given the wide scope of the government’s agenda for quality in the NHS,7 what value does publication of these measures in a newspaper add?8

Since the key to improving performance lies in partnership between those who provide and monitor the services and those who use them, a start might be made in future of providing more than four working days for trusts to check mortality data before publication. This would avoid the anger the first Dr Foster report generated when some trusts found that their data were incorrect. There is no substitute, however, for involvement of clinicians and users in discussions of how their data are to be used and presented. Without this, the key to effective further action will be lost once the oxygen of publicity is cut off. The London Health Observatory has provided a briefing and commentary on the new Dr Foster’s Guide to help trusts to interpret their own findings and decide whether further investigation is warranted.9

Maybe we should not worry as much as the cost of the activity is borne by Dr Foster and the Sunday Times;10 however the cost of dealing with questions arising from their publications is considerable. But will publication lead to genuine attempts to identify examples of poor practice and to address them? Evidence from the United States is not encouraging. In New York, after such information was made available, some surgeons with very low operating volumes and poor outcomes stopped operating, and death rates after cardiac surgery fell.11 But rates fell equally rapidly in states such as Massachusetts that did not publish death rates.12

What is clear is that publication leads to unintended changes in behaviour: cardiac surgeons were reported to be less willing to operate on high risk cases, a finding supported by cardiologists, who had more difficulty getting such patients treated.13 Publication also led to changes in data recording; for example, almost threefold increases in recorded rates of chronic obstructive pulmonary disease and over fourfold rises in congestive heart failure served to reduce severity adjusted mortality rates.14 Apparent improvements in recorded performance may be equally illusory in Britain—as shown by the recent frenetic activity to meet targets for waits in emergency departments; these lasted only for the week in which activity was recorded.15

1 Dr Foster Ltd. www.drfoster.co.uk (accessed 2 April 2003).