Investigation into GPs with high patient mortality

Monitoring death rates will become increasingly complex

EDITOR—Like Mohammed et al, we investigated several general practitioners (GPs) who signalled as having “unacceptably” high death rates in the study undertaken by Aylin et al.^{1,2} We also concluded that these higher than expected death rates were explained by a “nursing home effect.”

Our methods included calculating standardised mortality ratios for each general practitioner's registered population, and reviewing the case notes of dead patients. The review was conducted by two independent general practitioners using a structured form, based on that used in the original audit of Harold Shipman's practice.³

Identifying a nursing home effect is in itself an inadequate conclusion to an investigation of this type as quality of care may also be poor in this environment. Review of case notes, as a mechanism for formulating an impression of the quality of patients' care, is an essential, albeit resource intensive, adjunct to a purely statistical process.

Moreover, we agree that any national mortality monitoring system should accommodate the effect of nursing homes on case mix. Such adjustments would minimise the number of “false positive” signals and thereby reduce the sizeable burden of follow up investigation that will fall inevitably on primary care trusts.

Our investigation also highlighted the importance of distinguishing between general practitioner certified deaths and deaths of registered patients. Up to 60% of deaths certified by the general practitioners we investigated were of

patients registered with another general practitioner. As we move further towards team based models of general practice, the issue of monitoring mortality rates at individual practitioner level will become increasingly complex.

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Competing interests: None declared.

- 1 Mohammed MA, Rathbone A, Myers P, Patel D, Onions H, Stevens A. An investigation into general practitioners associated with high mortality flagged up through the Shipman Inquiry: retrospective analysis of routine data. *BMJ* 2004;328:1474-7. (19 June.)
- 2 Aylin P, Best N, Bottle A, Marshall C. Following Shipman: a pilot system for monitoring mortality rates in primary care. *Lancet* 2003;362:485-91.
- 3 Baker R. *Harold Shipman's clinical practice, 1974-1998*. London: Stationery Office, 2001.

Situation is even more complicated

EDITOR—This primary care trust inherited the Shipman affair and also had another general practitioner highlighted as having a high mortality in patients older than 65.¹ As medical director I had the task of sifting through 150 medical records and reconciling them with death certificates. There certainly seemed to be a nursing home effect.

Moreover, to apply the model as described will be difficult: even in our case deaths were ascribed to a particular general practitioner, although in some cases the doctor had never seen the patient, simply on the basis of registration. If mortality monitoring is to become part of routine assessment it will have to become highly complex to account for care by the whole of a multidisciplinary team. Attributing care to just one general practitioner will become difficult when patient lists are held on a practice basis.

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- 1 Mohammed MA, Rathbone A, Myers P, Patel D, Onions H, Stevens A. An investigation into general practitioners associated with high mortality flagged up through the Shipman Inquiry: retrospective analysis of routine data. *BMJ* 2004;328:1474-7. (19 June.)

Editorial independence at the *BMJ*

Oversight committee may be crucial step forward ...

EDITOR—With reference to Smith's Editor's choice on editorial independence at the *BMJ*,¹ we have witnessed the gutting of the *New England Journal of Medicine* and *JAMA* when their parent medical associations succumbed to their profound conflicts of interest. These associations' pursuit of revenue, coupled with their willingness to suppress papers that they or their advertisers didn't like, violated the editorial freedom of these journals' editors and diminished the prestige, credibility, and influence that these journals formerly enjoyed.

I believe that the current reorganisation of the *BMJ* and BMJ Publishing Group risks the same fate for the *BMJ*. This would be all the more tragic in light of substantial recent growth in the credibility and influence of the journal, not just in the United Kingdom but worldwide. The risk to the *BMJ* would be reduced by the creation of an oversight committee, constituted so that its membership is as free of professional and financial conflicts of interest as possible (with representation from, but not controlled by, the BMA Council).

This oversight committee would be tough with *BMJ* editors about how well they were applying high scientific standards in the review and publication of relevant submissions, and would scrutinise complaints about the journal's editorial policies and performance. Its crucial function would be to arbitrate editorial disputes between the *BMJ* and the BMA Council.

But to be effective, and to maintain the credibility and influence of the journal, the oversight committee's editorial decisions would have to be final. Oversight committees have been established recently at the *CMAJ* and *JAMA* (in the latter case, alas, too late to prevent serious damage). I believe that we could overcome the growing risk to the *BMJ*'s editorial freedom, credibility, and influence by creating a *BMJ* oversight committee now.

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Competing interests: See <http://bmj.bmjournals.com/cgi/content/full/324/7336/539/DC1>. In addition, DS is a member of the *BMJ* Editorial Board.

- 1 Smith R. Editor's choice. Editorial independence at the *BMJ*. *BMJ* 2004;329:0-g (10 July.)

...and could ensure three pronged terms of reference for editor

EDITOR—Sackett, in his response to Smith's Editor's choice on editorial independence at the *BMJ*, has argued cogently and clearly the case for an oversight committee to serve as defence, advocate, and guarantor of fidelity of future *BMJ* editors (preceding letter).¹

Stanley Fish, dean of the College of Liberal Arts and Sciences at the University of Illinois at Chicago, in a recent *New York Times* article, offered a piece of wisdom for academics, presumably including professors who are also journal editors.

He wrote: "Do your job; don't try to do someone else's job as you are unlikely to be qualified; and don't let anyone else do your job."²

These may be suitable terms of reference for the incoming editor, which the committee of oversight might ensure for him or her.

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- 1 Smith R. Editor's choice. Editorial independence at the *BMJ*. *BMJ* 2004;329:0-g. (10 July.)
- 2 Fish S. Why we built the ivory tower. *New York Times* 2004 May 12;section A:23.

Incident at Sri Lankan medical journal may show the way

EDITOR—Smith wrote about editorial independence at the *BMJ*.¹ A parallel situation exists in Sri Lanka.

The *Ceylon Medical Journal* is a quarterly publication of the Sri Lanka Medical Association. The two editors of the journal are appointed by the council of the association every three years and they become *ex officio* members of the council. The journal is independent, like the *BMJ*, although it bears no explicit statement that the views expressed in the journal are those of the authors and may not necessarily comply with the policy of the Sri Lanka Medical Association.

However, in August 2000 it was brought to the notice of the council that two fillers appearing under the caption "Economist on the LTTE" could damage the reputation of the Sri Lanka Medical Association because the *Ceylon Medical Journal* has been an official publication of the association.^{2,3} The journal's editors agreed to make observations to the council on this matter.

When comparing this situation to the *BMJ*, although the editors must be accountable, the new reporting arrangements of the *BMJ* editor must not affect editorial independence. The BMA tradition of editorial independence should be continued and should set an example to similar journals published in other countries. To ensure accountability, ideally an oversight committee should act as a buffer between the BMA and the editor.

This committee cannot infringe editorial freedom. It should remain as an advisory body on matters of controversial interests that affect the BMA. Eminent professionals and editors of other medical journals together with wider representation from outside the United Kingdom should be members. This would ensure a healthy atmosphere for discussion and deliberations that make the task of the editor easier.

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- 1 Smith R. Editor's choice. Editorial independence at the *BMJ*. *BMJ* 2004;329:0-g. (10 July.)
- 2 Economist on the LTTE(1). *Ceylon Med J* 2000;45:51.
- 3 Economist on the LTTE(2). *Ceylon Med J* 2000;45:54.

Guidance has high priority in interventional procedures

Objective evidence needs to be provided

EDITOR—The views expressed by Dent et al about new interventional procedures and about interventional clinicians are disturbing, particularly in view of the positions held by the authors.¹ Response from clinicians has been very poor. Is it apathy or acceptance?

Problems with interventional procedures were covered comprehensively, but the solutions proposed were for clinicians more training to evaluate procedures, for manufacturers to do more than the minimum, and for patients to be given more information. These are not proposals that are likely to assure safety for the unsuspecting patient, let alone set the field of interventional procedures alight.

Dent et al claim that new surgical and other interventional procedures are adopted without assessment of their safety and efficacy and offered to patients. This, in spite of the enforcement of clinical governance and the plethora of organisations responsible for patients' interests? There is an underlying moral and ethical dimension. Validity of the informed consent obtained for carrying out these procedures is also brought into question.

If prescribing of drugs is so well regulated, patients' safety demands greater control over interventional procedures. Self regulation has clearly failed. The National Institute for Clinical Excellence (NICE) plays a pivotal part in the delivery of health care, and its role should be expanded to regulate interventional procedures. New procedures should be notifiable, and progress reports submitted till cleared for use on a limited or wider basis.

The claim in the editorial, coauthored by the chairman of NICE's interventional procedures advisory group, that there may be cultural and educational reasons why interventional clinicians do not find rigor-

ous evaluation attractive is disturbing. It does not inspire confidence in the patients. I trust that these comments are based on objective evidence rather than on popular conceptions or misconceptions. Can we have the evidence please? Should such generalisations have escaped the editor's attention?

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Competing interests: AEJ is involved in developing a needle with improved detectability by ultrasound.

- 1 Dent T, Wortley S, Campbell B. New interventional procedures. *BMJ* 2004;329:3-4. (3 July.)

Author's reply

EDITOR—I thank Anton Jacob for his comments on our editorial. The poor and scanty evidence on which many new interventions are based is self evident. We tried to explore some of the possible reasons. We made no claim that there were studies or "hard" evidence for the suggestion of "cultural and educational reasons"—this comment was simply proffered as one possible reason for the continually poor provision of evidence. Editorials are a vehicle for opinion and debate, not just facts.

The words were actually written by my coauthor, Tom Dent, who is a public health doctor and therefore in a position to comment on the behaviour of "interventionalists" from a good vantage point. Traditionally, surgeons (the largest group of interventionalists) have had a culture of developing new techniques with an eye to their early outcomes but generally without recourse to setting up good comparative studies. Of course they have received education in scientific methods and they value good evidence when it becomes available, but, by and large, most surgeons around the world do not participate regularly in good comparative trials when they adopt new techniques. I think that this is "cultural" and it is therefore inevitable that it should be "educational"—if only by a process of example.

Jacob's comment, that discretion has to be exercised for the greater good, hints at a culture that is outmoded and inappropriate. At NICE we involve patients, carers, and other lay people in the most wide ranging and unfettered discussions about all aspects of health care. Debate about the possible reasons for the imperfect practice of doctors in all kinds of areas can become much more challenging and uncomfortable than the suggestion we have made in our editorial. We welcome open debate like this, because it encourages critical examination of our practices and prejudices, which can do nothing but good in the longer term.

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Scientific articles have hardly changed in 50 years

Plain English and minimal Latin may explain readability of 1950s paper...

EDITOR—I enjoyed reading Doll and Hill's paper from 1954 (four years before I was born), and, like Smith, I found it easier to read than present day papers.¹

Smith suggested that it was because it used the active voice and little jargon. I would go further and say that it used colloquial English, and only the normal amount of Latin derived words.

In those days patients had operations, done by surgeons, who then put them on antibiotics. Today they undergo surgical procedures, performed, undertaken, or carried out by surgeons, who then commence them on antibiotic medication. The three small red scars that resulted are now scars, three in number, red in colour, and small in length.

To be fair, most medical journal editors filter out this rubbish, but it is perpetuated in outpatient letters and discharge summaries—no doubt to medical secretaries' dismay.

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Competing interests: None declared.

¹ Smith R. Scientific articles have hardly changed in 50 years. *BMJ* 2004;328:1533. (26 June.)

...and "scientific rigour" may be to blame for current dullness...

EDITOR—The lack of imagination inherent in current scientific articles, as described by Smith,¹ could also be secondary to the format outlined by most journals and for what is believed to be a given for evidence based medicine and scientifically sound presentations.

Which journal would dare be different in accepting more innovative approaches to presenting clinical and scientific data?

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¹ Smith R. Scientific articles have hardly changed in 50 years. *BMJ* 2004;328:1533. (26 June.)

...but Asher was asking why medical journals were so dull back then

EDITOR—Smith notices little change in the format of medical papers in 50 years,¹ yet it was in 1958, almost 50 years ago, that Richard Asher asked: "Why are medical journals so dull?"²

May I suggest that Asher's small classic be a candidate for re-publication, if only to stimulate the next generation of editors and writers? Indeed, why are other classic *BMJ*

papers of the past not on the web? If a paper is not on the web it is (almost) lost to the collective memory.

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Competing interests: None declared.

¹ Smith R. Scientific articles have hardly changed in 50 years. *BMJ* 2004;328:1533. (26 June.)
² British Medical Association. *A sense of Asher: a new miscellany*. London: BMA, 1984:78-84.

Japan Tobacco Incorporated has found a new way of promoting tobacco in motor sports

EDITOR—Tobacco sponsorship of motor sports is an efficient way to reach boys and young men.¹ Japan Tobacco Incorporated, the world's third largest tobacco producer, had been advertising one of its bestselling brands in Formula One. Now it has found another way to promote smoking. Japan Tobacco has made a couple of mobile home-style trailers named "SmoCar."² They say smokers can enjoy a smoke in these special trailers even if smoking is not allowed in public places. SmoCar 2 travelled to event locations throughout Japan last year.³ Japan Tobacco claims that SmoCar has been developed as part of the company's initiative for increased coexistence between smokers and non-smokers in public spaces. I think secondhand smoke combined with exhaust fumes from "SmoCar" has become a health hazard for non-smokers in the vicinity of the car.

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Competing interests: None declared.

¹ Carlyle J, Collin J, Muggli ME, Hurt RD. British American Tobacco and Formula One motor racing. *BMJ* 2004;329:104-106. (10 July.)
² Japan Tobacco Incorporated. "SmoCar." www.jti.co.jp/JTI/tobacco/smocar/index.html (accessed 12 Jul 2004).
³ Japan Tobacco Incorporated. JT launches second mobile smoking space "SmoCar 2." www.jti.co.jp/JTI_E/Release/03/no23.html (accessed 12 Jul 2004).

Role of poverty must be emphasised

EDITOR—Malnutrition in children is the end point of a complex chain of causation, including infectious disease, traditional weaning practices, maternal (and paternal)

knowledge of child development, standards of hygiene, and much more. Underlying all of these is the real root cause—the unjust distribution of wealth and other resources both within and between countries. Government health workers are commonly the only professionals actively interested in children's malnutrition, and yet they are hampered by the health service's paradigm, which tends to see only the proximate causes and does not see a role for itself in tackling the deeper problems. A study such as the one by Powell et al might come about in two ways.¹ It might be part of a community development process, in which parents and carers are in the process of identifying the factors preventing their children from developing their full potential and are taking steps to tackle their situation and take more control over their lives. If so, this study is to be commended, and we would like to see more discussion of its community development aspects. If, on the other hand, this is just another study of proximate causes, with health workers once again deciding what is good for mothers and children without involving them in the process, then it will probably largely be wasted effort.

In addition, the study seems to accept culturally conditioned assumptions about the singular role of women as child rearers. Studies of this nature can lead to the belief that it is not food that is the problem but mothers who lack the requisite skills.² Regardless of the results of the study, the problems it tackles are not susceptible to a public health solution that simply addresses behaviour. Public health advocates must tirelessly reinforce the message that poverty is not consistent with good health.

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Competing interests: None declared.

¹ Powell C, Baker-Henningham H, Walker S, Gernay J, Grantham-McGregor S. Feasibility of integrating early stimulation into primary care for undernourished Jamaican children: cluster randomised controlled trial. *BMJ* 2004;329:89. (10 July.)
² Freedman L. Reflections on emerging frameworks of health and human rights. *Health and Human Rights* 1995;1(4):314-50.

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