

Hospital tables “should prompt authorities to investigate”

Zosia Kmietowicz *London*

The publication last weekend of death rates in hospital trusts throughout Britain has been hailed as a “courageous attempt” to compare the performance of hospitals, but one that offers little help to patients.

The research shows that for every 10 people who die in the best hospitals, 17 die in the worst, even after adjusting the figures for patients’ ages, sex, diagnoses, whether the admission was an emergency, and length of stay.

The biggest predictor of death rates was the number of doctors in the hospital and the area. The more doctors per bed and the more GPs per head of population, the lower the death rate. The analysis was carried out by Sir Brian Jarman, emeritus professor of primary health care at Imperial College of Science, Technology and Medicine in London.

Heading the league table for fewest deaths was University College London Hospitals, which boasted 63 doctors for every 100 hospital beds, whereas

Walsall Hospitals performed the worst, with just 23 doctors per 100 beds.

Sir Brian and his team used published death rates for NHS hospital trusts, adjusting them as far as possible to compare like with like. Social background was examined but found to be less significant than other factors included in the analysis.

A guide to hospitals in Britain and Ireland was published with the research in the *Sunday Times* which, together with publisher Dr Foster Ltd, commissioned the work.

Martin McKee, professor of European public health at the London School of Hygiene and Tropical Medicine, praised the research, calling it “a courageous attempt to try to compare the quality of hospitals.”

But he expressed concern about the methods used to compile the statistics, which took account only of deaths in hospitals and number of admissions while omitting 30 day mortality, multiple admissions, and whether there was a hospice close to the hospital.

Professor McKee added that, although patients may not find the figures very helpful—“a hospital that is performing poorly is generally known to the local population”—the results should prompt health authorities and primary care trusts to question why one hospital is performing less well than another.

The 10 English trusts with lowest mortality			
Health region	NHS trust	Mortality index	Doctors per 100 beds
London	University College London Hospitals	68	63
London	Barts and The London	70	53
London	Royal Free Hampstead	79	48
South East	Royal West Sussex	81	37
London	Chelsea and Westminster Healthcare	82	64
London	Guy's and St Thomas's	82	59
Northern and Yorkshire	Airedale	84	26
West Midlands	Hereford Hospitals	85	37
London	North West London Hospitals	85	53
South and West	Royal United Hospital, Bath	86	55

The 10 English trusts with highest mortality			
Health region	NHS trust	Mortality index	Doctors per 100 beds
West Midlands	Walsall Hospitals	119	23
Eastern	Mid Essex Hospitals	117	31
West Midlands	Sandwell Healthcare	117	29
South East	Heatherwood and Wexham Park Hospitals	115	33
Northern and Yorkshire	West Cumbria Healthcare	115	21
West Midlands	George Eliot Hospital	114	33
North West	Mid Cheshire Hospital	114	27
North West	Bolton Hospitals	113	25
North West	Burnley Healthcare	112	25
South and West	East Somerset	112	29

Ranking based on unrounded mortality figures

The best predictor of death rates is the number of doctors

Dr Azeem Majeed, senior lecturer in general practice at University College London and an epidemiologist with the Office for National Statistics, welcomed the increased availability of information on hospital standards but was concerned that the public would not be aware of its pitfalls.

“There are a number of problems if you are going to use this type of information as a guide to hospitals. The most

important is that there is huge variation within a hospital between the performance of different departments and the individual doctors within those departments, and this variation is wider than the differences between hospitals,” said Dr Majeed.

“These statistics tell us something, but not much. For example, if you had bowel cancer it won't tell you whether your doctor is any good.” □

Bone marrow transplants show no benefit for non-Hodgkin's lymphoma

Scott Gottlieb *New York*

Patients with aggressive non-Hodgkin's lymphoma do just as well when they are given standard chemotherapy for first line treatment as they do when they are treated with high dose chemotherapy and receive a bone marrow transplant, a new study shows.

The findings suggest that the more powerful and risky treatment of high dose chemotherapy followed by autologous bone marrow transplant should be reserved for patients in whom other treatments have failed, according to lead author

Dr Hanneke Kluin-Nelemans of Leiden University Medical Centre in the Netherlands and colleagues (*Journal of the National Cancer Institute* 2001;93:4-5, 22-30).

Last year, the only trial showing that bone marrow transplants for breast cancer could prolong life was discredited after the study's lead investigator was accused of serious scientific misconduct. Previously, the results of four breast cancer studies comparing high dose chemotherapy plus either bone marrow or stem cell transplant with standard chemotherapy found no extra

benefit from the more aggressive treatment (*BMJ* 2000;320:398).

In the current study the researchers randomised nearly 200 patients aged 15-65 with stage II-IV non-Hodgkin's lymphoma either to receive an autologous bone marrow transplant or to be in a control arm in the trial. The patients had all already received three cycles of a drug regimen known as CHVMP/BV, which combines cyclophosphamide, doxorubicin, teniposide, and prednisone, with bleomycin and vincristine added at mid-cycle.

Of the 194 participants, 140 were of low or low to intermediate risk according to the international prognostic index. Participants in the group receiving a bone marrow transplant received another three cycles of CHVMP/BV, followed by a regimen known as BEAC, which is a combination of carmustine, etoposide, cytarabine,

and cyclophosphamide. The controls received five more cycles of CHVMP/BV.

Follow up at 53 months showed that 61% of the participants who received a bone marrow transplant were free of disease progression and 68% were still alive; in the control group the corresponding proportions were 56% and 77%. The difference between the two groups was not significant, and therefore no benefit from the combination therapy and bone marrow transplant can be inferred.

Dr Richard Fisher, professor of medicine at Loyola University in Chicago, Illinois, wrote in an accompanying editorial that there seemed to be no indication to add autologous bone marrow transplant plus high dose chemotherapy to the initial combination chemotherapy for all patients with aggressive lymphoma. □