review was maintained. Far from being "black boxes," the components of these approaches are clearly discernible and essential for any successful system: shared records; improved communication between doctors and with patients; a clear role for the patient; specialist input (for example, screening of results from general practice or an annual consultation); agreed management plans (which can be flexible to accommodate preferences); and the possibility of patients moving up and down the levels of care and a fail safe system for coordination.

In the management of chronic disease a structured approach to matching levels of care to need and ensuring long term follow up has already been shown to be cost effective. We believe that these findings are widely applicable in the health care services. The next generation of trials should be concerned with identifying the best approaches to shared care, not comparison with traditional methods. Furthermore, all shared care should incorporate routine evaluation, including, in the longer term, assessment of clinical outcomes.

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Consultants' response to clinical complaints

EDITOR,—Nicholas Summerton reports a questionnaire survey of general practitioners to investigate their defensive medical practices.[1] We recently completed a similar study for Oxford Regional Health Authority, which examined the impact of clinical complaints on hospital consultants. The views of all 848 consultants in the region were surveyed, and replies were received from 443 (52%), 246 of whom had received at least one complaint.

A major finding was that much activity in response to complaints occurs in the shadow of the formal procedures. Most consultants tended to respond directly to the complainant even though the patient's charter now calls for all responses to complaints to come from senior management. On at least one occasion 136 consultants had contacted the complainant by letter or telephone or had had a face to face encounter with the complainant as their first response to the complaint without liaising with a manager. Consultants who took such action were likely to have done so for one of three reasons. Firstly, if they had received the complaint personally they thought that it was a courtesy to respond directly to it. Secondly, some did not know of the existence of the formal complaints procedure and the management role in it. Finally, a large proportion did not think it appropriate for managers to respond to complaints about clinical care.

Complaints have an important effect on consultants at an emotional level, which is particularly striking when the complaint is considered to be unjustified. Consultants rely heavily on medical networks when they receive a complaint and hardly ever seek support from management. Complaints also have a major impact at a professional level. Extensive evidence of defensive medicine was not found. Rather, many of the responses indicated an improvement in patient care—for example, better record keeping (42 responses), fuller consultations with patients (37), and increased clinical vigilance (32)—as a response to complaints.

Our research shows that much needs to be done to forge partnerships between clinicians and managers for handling complaints. While existing networks go some way towards alleviating the harmful effects of complaints, our findings show that consultants need greater reassurance and support when they believe that they are the subject of an unfair complaint.

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1 Summerton N. Positive and negative factors in defensive medicine: a questionnaire study of general practitioners. *BMJ* 1995;310:27-9. (7 January.)

Interpreting hospital death rates

EDITOR,—N W Harry raises several issues related to the indicators of clinical outcome published by the Clinical Resources Advisory Group.[1] As he rightly points out, the intention was to promote discussion about variations, and if the information has been used in league tables that is contrary to the specific advice repeatedly given in the report and in related briefing. Copies of the report and briefing for handling inquiries were sent one week before publication to all chief executives and medical directors of trusts in Scotland. Several, including Harry, discussed these with central information services, but, clearly, misunderstandings persist.

Elderly people were not included by mistake. The specific intention was to include all patients with acute myocardial infarction because all should receive optimal care regardless of age and the hospital to which they are admitted. The tables are standardised for age and sex and consequently draw attention to variations that should be examined.

Harry questions the assignment of patients to his trust. All trusts were treated in the same way—namely, by all hospitals constituting a trust on 1 August 1994 being included. The table shows results for Fife Healthcare NHS Trust. They include Milesmark Hospital (now closed), but it is clear that, during the period analysed, mortality for Fife Healthcare arose largely from admissions to the smaller community hospitals and the geriatric specialties in the Victoria Hospital. Particular care should be taken in interpreting results when any hospital is divided between trusts according to specialties. Thus reference to Queen Margaret Hospital NHS Trust is inappropriate.

Some medical directors continue to express anxiety about the exercise, but it was agreed, after detailed consultation with the Medical Directors' Group and other professional groups in Scotland, that professional practice and improved care would best be served by openness. The Scottish Association of Local Health Councils has reported no public disquiet about the report. Unnecessary anxiety seems to have been restricted to Fife Healthcare Trust's sphere of influence.

Professional staff and the media have, overall, received the report seriously and constructively. Health boards have been asked to initiate local discussions about the variations, and my working group will be supporting that initiative and continuing to work on refining the existing indicators and developing new ones.

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1 Harry NW. Interpreting hospital death rates. *BMJ* 1994;310:599. (4 March.)

Applicants for senior medical positions in New Zealand

EDITOR,—The New Zealand public health service is going through a process of rapid restructuring, and the employers of salaried senior medical staff are now known as crown health enterprises. Coupled with this change is New Zealand's unique industrial law. For example, there is no longer the lawful ability to negotiate national terms and conditions of employment, and what right employees have to contract negotiation is nominal, lacking effective procedures or obligations. Negotiations now have to be conducted with each separate crown health enterprise (there are 23). The Association of Salaried Medical Specialists, which is affiliated to the New Zealand Medical Association, is responsible for the negotiation of collective contracts with these crown health enterprises.

If readers of the *BMJ* are considering applying for, or have been offered, positions in a New Zealand crown health enterprise they are strongly advised to seek the advice of the association. We can be contacted at PO Box 5251, Wellington, New Zealand (tel 0064 4 499 1271; fax 0064 4 499 4500). As the conditions of employment vary and there are different perspectives on the employment of senior medical staff among (in fact sometimes within) different crown health enterprises, professional industrial advice is strongly recommended. You can be materially disadvantaged without it.

There are at least two crown health enterprises with which particular care should be taken. One, contrary to the wishes of currently employed staff, is seeking to employ new senior medical staff on significantly different, inferior, and deceptive individual contracts. The other is refusing point blank to negotiate a collective contract and instead is offering disadvantageous individual contracts in opposition to senior medical staff. In all cases, applicants and those offered positions are encouraged to seek the advice of the association.

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Deaths occuring within 30 days of admission as percentage of all admissions with acute myocardial infarction, Fife Healthcare NHS Trust and Scotland overall, October 1990 to September 1993

	Patients admitted	Died within 30 days	Mortality (%)	Standardised mortality rate (95% confidence interval) (%)
Patients assigned to Fife Healthcare NHS Trust	885	292	32·99	29·56 (26·26 to 33·15)
Victoria Hospital, Kirkcaldy (geriatric specialties)	88	59	67·05	37·59 (28·61 to 48·51)
Queen Margaret Hospital (geriatric specialties)	2	1	NA	NA
Milesmark Hospital	652	155	23·77	25·42 (21·57 to 29·75)
Forth Park Hospital	3	0	NA	NA
Other hospitals in trust	140	77	55·00	36·04 (28·44 to 45·06)
Rest of Scotland	39 305	8240	20·96	21·02 (20·57 to 21·48)
Scotland	40 190	8532	21·23	21·23

NA=Not applicable.