

### Meaning of the study

We believe that publishing surgeon specific, crude mortality data,<sup>2</sup> as is planned in the United Kingdom, is not in the best interests of patients, and our study shows that surgeons cannot be compared fairly in this way. Cardiac surgeons already work in a stressful environment, and the perception that a “bad run” might jeopardise their career or result in suspension and investigation may lead to a tendency to turn down high risk cases. The easiest way to obtain low mortality is to do only straightforward operations—so called risk averse behaviour. This has already been identified as a potential problem after a survey of all cardiac surgeons in the United Kingdom in 2000, where 94% of responders agreed that high risk patients were being turned down for surgery.<sup>1</sup> Death rates in these patients often approach 100% if the patients are denied surgery and patients at heightened risk from surgery are, in general, those who have the most to gain from a successful operation.<sup>21</sup> Our recommendation of benchmarking only low risk patients seems scientifically justified and pragmatic and should help to prevent risk averse behaviour.

### Unanswered questions and future research

Some evidence from North America sheds light on the effects of publication of surgeon specific data on patients, cardiologists, and surgeons,<sup>1 22 23</sup> but we do not know to what extent initiatives to publish crude mortality data for individual surgeons will actually deny operations to high risk patients, and what implications this will have on patients' survival, quality of life, and use of healthcare resources. This is an important area for future studies. Further investigations are also needed on high risk patients, to improve the quality of risk prediction in this group, and to understand variability in outcomes following high risk surgery for quality improvement purposes.

This study has been conducted on behalf of the North West Quality Improvement Programme in Cardiac Interventions, and the participating consultant surgeons are listed as follows: John Au, Ben Bridgewater, Colin Campbell, John Carey, John Chalmers, Walid Dhimis, Abdul Deiraniya, Andrew Duncan, Brian Fabri, Elaine Griffiths, Geir Grotte, Ragheb Hasan, Tim Hooper, Mark Jones, Daniel Keenan, Neeraj Mediratta, Russell Millner, Nick Odom, Brian Prendergast, Mark Pullan, Abbas Rashid, Paul Waterworth, Nizar Yonan. We would like to acknowledge the assistance of the audit officers working in each centre for their hard work in collecting and validating the data.

Contributors: BB had the idea for the study and with ADG and MJ was responsible for the study design. Data analysis was performed by ADG and MJ. The manuscript was prepared by BB and ADG. All authors contributed to writing the paper, which was written on behalf of the North West Quality Improvement Programme in Cardiac Interventions. BB will act as guarantor.

Funding: All primary care trusts in the north west of England.

Competing interests: None declared.

Ethical approval: The project was conducted on routinely collected prospective data. All patient identifiers were anonymised. The study therefore did not need ethical approval.

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(Accepted 17 June 2003)

### Corrections and clarifications

*ABC of diabetes: cardiovascular disease, hypertension, and lipids*

Owing to an electronic problem, we had to retype many of the symbols in this article by Peter J Watkins, and inevitably we slipped up on one (19 April, pp 874-6). The fourth paragraph in the section on blood pressure management should read: “Blood pressure > 140/80 mm Hg [not < 140/80 mm Hg] should be treated if there is evidence of organ damage ... The target pressure is < 140/80 mm Hg.”

*Accuracy of Ottawa ankle rules to exclude fractures of the ankle and mid-foot: systematic review*

An error crept into the diagram of the Ottawa ankle rules in this article by Lucas M Bachmann and colleagues (22 February, pp 417-9). The medial view of the ankle should have been labelled: “Posterior edge or tip of the medial [not lateral] malleolus—6 cm.”