LETTERS

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DOCTORS' PERFORMANCE

Professional societies can lead the way but will need support

Tavare and Godlee ask what national professional societies are doing about professional transparency and outcome data.[1 2] Such transparency should be part of a wider package of measures to improve services to patients.

Clinicians are suspicious about outcomes based on poor quality data, such as hospital episode statistics, and experience of cardiac surgery shows that transparency requires the confidence provided by systematic collection and sophisticated analysis of high quality datasets. The National Institute of Cardiovascular Outcomes Research now hosts seven national cardiac audits,[3] mostly developed with limited resources by enthusiastic people on behalf of professional societies. Some of these will allow individual risk stratified outcome data. National audits also provide important information about the performance of teams and institutions.[4]

For areas such as imaging, outcome data are hard to provide, although measures of service quality, such as the British Society of Echocardiography online quality improvement tool[5]—now incorporated into the National Improving Quality in Physiological Diagnostic Services programme—are available. Can we do more? In addition to securing central funding for national audits and realising their potential, quality improvement programmes must be extended to areas where outcome data are less easy to provide. Professional societies should set standards and identify the limits of safe acceptable practice; but who investigates and acts on potential problems? Who carries the indemnity for decisions made on the basis of data provided by professional societies? Embedding a culture of transparency will require the active engagement of all parties and a clarity about their roles and relationships that does not yet exist. Professional societies can lead the way, but they will need the support of commissioners, regulators, and government.

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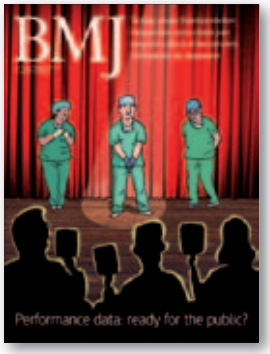
Competing interests: None declared.

1 Tavare A. Where are we with transparency over performance of doctors and institutions? *BMJ* 2012;345:e4464. (3 July.)
2 Godlee F. Measure your team's performance, and publish the results [Editor's Choice]. *BMJ* 2012;345:e4590. (4 July.).
3 National Institute of Cardiovascular Outcomes Research. www.ucl.ac.uk/nicor.
4 Myocardial Infarction National Audit Project. www.ucl.ac.uk/nicor/audits/minap.
5 British Society of Echocardiography. www.accredityourdepartment.org.

Cite this as: *BMJ* 2012;345:e5075

Patient reported measures are needed

The results of the recent national audit of the acute stroke care of nearly 9000 patients (by the Royal College of Physicians (RCP) on behalf of the intercollegiate stroke working party) are free online.[1 2] The public, clinicians, managers, and commissioners can easily compare how their local stroke teams are performing against national standards. The national sentinel stroke audit has published its results online since 2006; last year we compiled individual constituency reports for every MP. We take similar approaches with other audits.



Most doctors support increased transparency but want reassurance that measures accurately and fairly represent the quality of their care.[3] Measuring quality in chronic conditions or complex medical problems is not as straightforward as in some surgical procedures, but it can be done. It requires a suite of measures, including clinical outcomes, and the use of patient reported measures. After all, poor communication and poor experience of care (not concerns about clinical care) underlie most patient dissatisfaction and most complaints.[4 5] Patient reported measures are not well developed for most medical conditions, but we are using some of our other clinical audit programmes to develop these.

The RCP's Future Hospital Commission, due to report in 2013, will include work on understanding, measuring, reporting, and improving the quality of care for medical patients. Integral to this work will be the public reporting of quality metrics. We shall be seeking contributions from professional, academic, and commercial organisations with an interest in this area, including the *BMJ*.

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1 Godlee F. Measure your team's performance, and publish the results [Editor's Choice]. *BMJ* 2012;345:e4590. (4 July.)
2 Intercollegiate Stroke Working Party. Stroke Improvement National Audit programme. Royal College of Physicians, 2012. www.rcplondon.ac.uk/sinap.
3 Tavare A. Where are we with transparency over performance of doctors and institutions? *BMJ* 2012;345:e4464. (3 July.)
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5 National Clinical Assessment Service. www.ncas.nhs.uk/publications/.

Cite this as: *BMJ* 2012;345:e5048

Don't blame individuals for organisational failures

The Vascular Society has published numerous reports on the performance of vascular procedures.[1] In March 2012, we published mortality data after elective abdominal aortic aneurysm repair for every trust in the UK and were disappointed that it was not accepted for publication in the *BMJ*.[2] The report showed that a quality improvement programme implemented by our society was associated with a reduction in national mortality rates—from 8% to 2.4%—which is lower than in many European countries. Using more stringent criteria than those of the Society for Cardiothoracic Surgery, the report identified three borderline performing and five non-contributing units. This information was reported to the medical directors of these trusts.

Surgeons should not always be blamed for poor performance, however. Service delivery in vascular medicine has changed greatly. Many procedures (especially open abdominal aortic aneurysm repair) now involve preoperative multidisciplinary team assessments, joint consultant operations, specialist vascular anaesthetists, and a highly trained team that cares for patients in intensive care and on the ward. Failures therefore need to be analysed carefully to identify reasons for poor outcomes. Some years ago, Great Ormond Street Hospital identified failures at handover between the operating theatre and intensive care as the point at which babies were at greatest risk.[3] Poor outcomes can therefore be caused by system failures rather than poor operative technique.[4]

If we are to modernise our health service, the culture needs to encourage services to improve. This cannot be achieved by blaming an individual for an organisational failure. Being open about results and encouraging teams to improve is the key.

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Cite this as: *BMJ* 2012;345:e5058

Good question, wrong answer

Although the extent to which national clinical databases publicly disclose comparisons of the quality of providers' care is an important question to answer, Tavare does not acknowledge that most of the leading databases already do this.[1] These include, among others, adult critical care (Intensive Care National Audit and Research Centre's case mix programme database), severe trauma care (Trauma Audit and Research Network), lung cancer (National Lung Cancer Audit), neonatal intensive care (National Neonatal Audit), hip fracture (National Hip Fracture Database), coronary angioplasty, hip and knee replacement (National Patient Reported Outcome Measures programme), acute stroke care (Stroke Improvement National Audit programme), and paediatric intensive care (Paediatric Intensive Care Audit Network).

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1 Tavare A. Where are we with transparency over performance of doctors and institutions? *BMJ* 2012;345:e4464. (3 July.)

Cite this as: *BMJ* 2012;345:e5055

Grand scheme of disclosure?

Although Tavare presents evidence for both sides of the argument on the quality of performance data, he still gives a positive slant to public disclosure,[1] probably because of bias in selecting opinions from those with a vested interest in the venture. For example, the names of the founders of Dr Foster appear no fewer than a dozen times. So, what else can we expect but favourable comments?

Referring to the problems with performance data, Keogh stated in 2008 that "the shortcomings are not important in the grand scheme of public disclosure."[2] Both Tavare and Godlee cite this quotation but do not comment on this extraordinary view.[1 3] Are errors with data really to be dismissed in such a cavalier fashion? Does the quality of the data not matter? It has recently become clear that mortality statistics are unreliable, and it has been recommended that hospital standardised mortality ratios are abandoned altogether.[4] Given that death is the hardest of endpoints, we can only guess about other data based on softer outcomes. Statistical data can so readily be misinterpreted, manipulated, and abused that we can have little confidence in their reliability.[5]

When the data are suspect, the information provided to patients is of little value. Public disclosure becomes nothing but a sham. And what about the effect of the process on clinicians who may be held to account for their poor performance on the basis of faulty statistics? Patients and doctors would be well advised to be sceptical about this "grand scheme of public disclosure."

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1 Tavare A. Where are we with transparency over performance of doctors and institutions? *BMJ* 2012;345:e4464. (3 July.)
2 Keogh BE. Presidential address: a decade of immunisation, 2008. www.scts.org/_userfiles/pages/file/Presidential%20address-Keogh.pdf.
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Cite this as: *BMJ* 2012;345:e5052

VTE PROPHYLAXIS

Heparin prophylaxis has no benefit in medical patients

The article on the introduction of methods to encourage or mandate the prescription of prophylaxis for venous thromboembolism (VTE) is misconceived.[1] It is not true that most cases of deep vein thrombosis (DVT) in medical patients can be prevented. A recent meta-analysis found that symptomatic DVT occurred in 0.79% of patients given prophylaxis with heparin versus 0.96% of controls, with a mortality of 6.5% versus 6.6% (table).[2]

Another recent study also showed no benefit for heparin prophylaxis.[3] These results are not surprising given that the reduction in symptomatic VTE is the same as the increase in bleeding in patients given heparin.[2] In the light of National Institute for Health and Clinical Excellence guidance on how risks and benefits are presented to patients, advice that VTE prophylaxis be offered to patients with medical conditions is perplexing.[4 5]

Patients admitted to hospital with a medical condition (excluding stroke) could be counselled as follows:

- You have about a 10 in 1000 chance of developing a blood clot in your veins that will cause symptoms during your admission and about a three in 1000 chance of dying from a blood clot in the next three months.
- A daily injection would reduce these risks to about eight in 1000 and two in 1000, respectively. However, the chance of bleeding would increase from 27 in 1000 to 47 in 1000 and the chance of having a serious (life threatening) bleed from two in 1000 to three in 1000.

I doubt, given this information, that many patients (or doctors) would consider heparin to be worthwhile.

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Competing interests: None declared.

1 Streiff MB, Carolan HT, Hobson DB, Kraus PS, Holzmueller CG, Demski R, et al. Lessons from the Johns Hopkins Multi-Disciplinary Venous Thromboembolism (VTE) Prevention Collaborative. *BMJ* 2012;344:e3935. (19 June.)
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Outcomes of heparin prophylaxis in non-surgical patients[2]

Outcome	Studies (N)	Heparin group, n/N (%)	Control group, n/N (%)	Peto odds ratio (95% CI)	Absolute effect per 1000 patients treated (95% CI)
Mortality	10	679/10 466 (6.5)	679/10 251 (6.6)	0.94 (0.84 to 1.04)	−4 (−11 to 3)
Symptomatic DVT	5	25/3166 (0.79)	27/2791 (0.96)	0.78 (0.45 to 1.35)	−2 (−6 to 4)
PE	10	88/10 466 (0.84)	127/10 251 (1.2)	0.69 (0.52 to 0.90)	−4 (−6 to -1)
PE associated death	6	50/10157 (0.49)	53/9937 (0.53)	0.93 (0.63 to 1.38)	0 (−2 to 2)
Fatal PE	5	21/8927 (0.24)	26/8693 (0.30)	0.77 (0.43 to 1.37)	−1 (−2 to 1)
All bleeding events	8	216/4550 (4.7)	115/4194 (2.7)	1.34 (1.08 to 1.66)	9 (2 to 18)
Major bleeding events	9	41/10 331 (0.40)	25/10 116 (0.25)	1.49 (0.91 to 2.43)	1 (0 to 3)

*DVT=deep vein thrombosis; PE=pulmonary embolism.

4 National Institute for Health and Clinical Excellence. Venous thromboembolism—reducing the risk. CG92. 2010. www.nice.org.uk/cg92.
5 National Institute for Health and Clinical Excellence. Patient experience in adult NHS services. CG138. 2012. http://publications.nice.org.uk/patient-experience-in-adult-nhs-services-improving-the-experience-of-care-for-people-using-adult-cg138.

Cite this as: *BMJ* 2012;345:e4940

JAMES KING HOLMES / SPL

NICE ON VTE DISEASES

Time frames for radiography are unrealistic

The members of the Guideline Development Group must work in a fantastically well resourced environment where ultrasound scans to diagnose deep vein thrombosis of the leg are freely available, because their recommendation for the scan to be provided within four hours of request was based on personal opinion.[1] I cannot imagine many radiology departments being able to match this ambition seven days a week, or even the alternative of a scan within 24 hours while patients are started on anticoagulants. I wonder why the group members stopped short of recommending an equally precise and stringent time frame for the provision of computed tomography pulmonary angiography in patients with suspected pulmonary embolism. Perhaps they realised by this stage of guidance development the unrealistic nature of these time frames.

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Competing interests: None declared.

1 Chong L-Y, Fenu E, Stansby G, Hodgkinson S; on behalf of the Guideline Development Group. Management of venous thromboembolic diseases and the role of thrombophilia testing: summary of NICE guidance. *BMJ* 2012;344:e3979. (27 June.)

Cite this as: *BMJ* 2012;345:e5076

NICE guideline has weaknesses

CG144 provides a comprehensive review of the literature and useful practical guidance, but two aspects puzzle me.[1 2]

Firstly, the Guideline Development Group (GDG) provides no empirical evidence for changing from the current practice of immediate treatment with low molecular weight heparin (LMWH) and scanning when feasible (often in usual working hours) to scanning within four hours in patients with suspected venous thromboembolism.

On pages 83-4 it says: "A single dose of parenteral anticoagulant is likely to have an overall benefit to patients who are waiting for diagnostic imaging to exclude a pulmonary embolism," and "The GDG decided to recommend anticoagulation if diagnosis of pulmonary embolism cannot be confirmed immediately based on safety reasons; no economic evidence was considered to inform this recommendation."

On page 87 it says: "There was no clinical evidence review regarding the use of anticoagulants while waiting for imaging in patients with 'likely' . . . pulmonary embolism." It also says, "putting patients on LMWH is expensive and may expose them to unnecessary side effects." Again, no evidence is provided and no assessment is made of the cost of reorganising on call arrangements for ultrasound scanning.

Without quantitative data, how can we know whether such a major rearrangement is worthwhile, especially when cash strapped trusts have to reduce costs?

Secondly, the recommendation for investigating cancer in patients with idiopathic venous thromboembolism is based on low quality evidence and does not mention the morbidity associated with false positive diagnoses.[3]

Perhaps it is premature to recommend major changes when the empirical evidence is partial and the impact on practice will be massive.

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1 Chong L-Y, Fenu E, Stansby G, Hodgkinson S; on behalf of the Guideline Development Group. Management of venous thromboembolic diseases and the role of thrombophilia testing: summary of NICE guidance. *BMJ* 2012;344:e3979. (27 June.)
2 National Institute for Health and Clinical Excellence. Venous thromboembolic diseases: the management of venous thromboembolic diseases and the role of thrombophilia testing. CG144. 2012. http://guidance.nice.org.uk/CG144/Guidance/pdf/English.
3 Wise J. NICE recommends cancer tests for unexplained blood clots. *BMJ* 2012;344:e4396. (27 June.)

Cite this as: *BMJ* 2012;345:e5099

Health warning—not all evidence based

Readers and clinicians should review the detailed guidance before blindly following the summary advice because[1]:

- It recommends thrombolysis for certain patients with deep vein thrombosis, but the original guidance rates the studies as "low quality with serious imprecision" and recommends further research
- It also recommends thrombophilia testing, although the detailed guidance acknowledges that this may not be clinically or cost effective. Again, the full guidance recommends further research
- Apart from physical examination, baseline blood tests, and chest radiography, which are usually done, the group recommends considering computed tomography (and mammography for women) to screen for cancer. However, the detailed guidance acknowledges that the quality of studies is low, that this exposes patients to radiation, and that this may increase distress from false positives. Again it recommends further research.

Readers who rely solely on the summary guidance must be aware that, perhaps because of space limitations, the summary did not articulate these reservations. This also serves as a reminder not to blindly follow National Institute for Health and Clinical Excellence guidance because the evidence base may not be robust. More helpfully, these reservations should have been included in the summary, or better still, the grade of evidence supporting the recommendation mentioned; perhaps it was deliberately omitted because it was level C (expert opinion) and not grade A?

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1 Chong L-Y, Fenu E, Stansby G, Hodgkinson S; on behalf of the Guideline Development Group. Management of venous thromboembolic diseases and the role of thrombophilia testing: summary of NICE guidance. *BMJ* 2012;344:e3979. (27 June.)

Cite this as: *BMJ* 2012;345:e5078

No evidence on screening for cancer

The National Institute for Health and Clinical Excellence (NICE) now recommends screening for cancer in patients aged over 40 years with a first unprovoked deep venous thrombosis or pulmonary embolism. However, this comprises a small section of the venous thromboembolism (VTE) guideline,[1] which otherwise adds little to existing guidelines. The British Thoracic Society and European Society of Cardiology concluded that screening for cancer is not warranted in patients with unprovoked VTE, because occult

cancer will be detected by history taking and performing a physical examination.[2 3] How the NICE Guideline Development Group decided that screening should be performed in patients with no symptoms or signs of cancer requires further scrutiny.

This recommendation is based on one unblinded trial that did not achieve its primary outcome.[4] When an intensively screened group was compared with a usual investigation group, the 95% confidence intervals for the relative risk of two year cancer related mortality were wide and encompassed unity (0.1 to 2.75), indicating no significant effect. Inexplicably, the group's interpretation was "there may be a decrease which is potentially clinically important in cancer related mortality." The group tries to justify itself on the grounds that cancer associated VTE is treated differently, but this evidence comes from a completely different patient population.[5] The psychological and physical harms caused to patients by the discovery of incidental lesions on computed tomography were not considered. The group advocates screening because patients want it, but the arguments for and against screening are complex, so patients deserve unbiased advice from NICE. Instead, the group seems to have misinterpreted the evidence so that NICE can pronounce that its guideline is different.

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Cite this as: *BMJ* 2012;345:e5079

Authors' reply

Your correspondents raise several issues about CG144, most of which are dealt with in the full guideline,[1] including how the evidence for each outcome was considered and graded. We would encourage them to read it. National Institute for Health and Clinical Excellence (NICE) guidance consistently uses "offer" and "consider," words that acknowledge patient choice in treatment decisions and are standard vocabulary in all its guidance. We agree that high quality evidence is lacking in several areas. However, when clinical and economic evidence were of poor quality, recommendations were based on the evidence available and Guideline Development Group consensus.[2] The decision to request ultrasound scanning preferably within four hours and always within 24 hours for the diagnosis of deep vein thrombosis is a quality of care issue aimed at protecting people from being exposed to potential harm from receiving unnecessary low molecular weight heparin. It is appropriate that the modern NHS has a "seven days a week" approach to the provision of important investigations despite resource problems.

Patients with unprovoked venous thromboembolism have a 10% risk of cancer, which exceeds the accepted threshold of a 2.4% positive predictive value in investigating patients with haemoptysis for lung cancer.[3] The guideline group, including patient representatives, took the view that people would wish to know this level of risk. To suggest otherwise seems paternalistic. The comment that information on the quality of underlying evidence was perhaps deliberately omitted is a serious and unsubstantiated charge, because statements on the strength of evidence immediately follow the recommendations in the guideline. Hart's suggestion that routine history and examination detect most patients with underlying cancer is also incorrect. As shown in the SOMIT study, 43% of patients with cancer are not detected by these routine measures, while additional tests such as abdomopelvic computed tomography are 93% sensitive in diagnosing these cancers.[4 5]

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Cite this as: *BMJ* 2012;345:e5098

CHALLENGE OF MULTIMORBIDITY

Collaboration between primary and secondary care is needed

It is surprising that in their excellent editorial Mangin and colleagues did not refer to the specialty of geriatric medicine, which takes a generalist holistic approach to illness in older people.[1]

When done properly, geriatric medicine comprises the identification of comorbidities in frail older people and the use of clinical judgment to decide when to treat, and to what extent.

Many such patients are approaching the end of their lives and many also have (often undiagnosed) dementia, which makes the task even more difficult.

It is questionable whether primary care, as currently configured in the UK, can provide the only answer to managing older people with multiple comorbidities, especially when they continue to appear in increasing numbers in medical admissions units up and down the country.

A collaborative approach between generalists in both primary and secondary care is surely required to deal with the needs of these patients.

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Competing interests: None declared.

1 Mangin D, Heath I, Jamoulle M. Beyond diagnosis: rising to the multimorbidity challenge. *BMJ* 2012;344:e3526. (13 June.)

Cite this as: *BMJ* 2012;345:e5148