Will league tables have an adverse effect on the practice of coronary revascularisation in the UK?

Within the last year we have witnessed the advent of public scrutiny of the results of surgical coronary revascularisation. The methodology employed in order to achieve this scrutiny was flawed, as was the way the inadequate and incomplete results were presented to the general public. Data were presented without careful critical appraisal of what the figures actually meant. Little or no account was taken of context, risk assessment or case mix. This was either because of ignorance upon the part of those involved in publication or because of an inadequate level of concern for accuracy. In either case it was irresponsible. Inevitably, to make matters worse, any attempt to explain the fallibility of the presented figures and the flaws in their interpretation has lead to the charge of having something to hide.

The unpleasant experience of the cardiac surgeons is almost certainly to be shared by interventional cardiologists in the not too distant future. The desire not to be near the bottom of a league table published in the national press is powerful. Will it change our practice? Clearly, it already has changed the practice of many cardiac surgeons, who now turn down 'high-risk' cases, thus denying such patients the chance of survival or improvement in symptoms offered by surgery. Is it not already also affecting the behaviour of interventional cardiologists? For example, intervening upon a patient with cardiogenic shock may reduce their mortality rate from 70–80% to around 50%. But if the last case that I did died, will I be so keen to take on the next one? My personal figures will look a lot better if I never take on any patients in this high-risk group.

So where do we go from here? The answer may be to take charge of these results and tables ourselves. In general, the cardiac surgeons are considerably ahead of interventional cardiologists in terms of acquisition and audit of their outcome data. Newer, sophisticated systems mean, however, that in both specialties there will soon be robust databases, with universally accepted datasets in place all over the UK. It remains for us to analyse and present the outcome data in a universally accepted manner that contains a rigid framework built into it that incorporates risk assessment and case complexity. Such data can then be produced in a transparent and digestible pattern for public consumption, having been scrutinised by a creditable independent body.

In this issue, Steve Westaby presents his personal analysis of the process of risk assessment and production of tables. He offers a sobering assessment of how the methodology employed to produce risk-specific outcome data can itself be manipulated. It is clear that the production of accurate, meaningful and patient-protective figures depends upon an awareness of these factors as well as datasets and computer software. The appearance of such figures in the public domain carries with it a responsibility for education of the people who will receive them so that they can genuinely access the issues involved. Above all, such data presentation will rely upon an integrity that has so far been missing in the sensation-seeking organisations involved. If we have nothing to hide and we are aiming to produce the highest standards of clinical care for our patients then we owe it to ourselves to insist upon taking charge of the production of these tables.

We must be protected from developing a defensive strategy when we have the opportunity to revascularise patients who are high-risk cases. Otherwise these league tables will cost lives and quality of lives.

Nick Curzen
Consultant Cardiologist
Manchester Heart Centre, The Royal Infirmary,
Manchester, M13 9WL.
(email: nc@mhc.cmht.nwest.nhs.uk)

Br J Cardiol (Acute Interv Cardiol) 2002;**9**(1):AIC 11