

On Reflection

What are my chances, doc?

I have only been successfully sued once in my journalistic career—over a story about hospital death rates. I had obtained details of death rates after general surgery across the country that showed a six-fold variation and I produced a league table that appeared in the newspaper for which I then worked. Unwisely, as it turned out, I made critical remarks about the areas with the worst rates, on the basis of a report suggesting that extra deaths could indicate incompetent surgeons or poor nursing care. The named hospitals took umbrage and, on the advice of the paper's lawyer, the dispute was settled quickly.

That was over 15 years ago. 5 years later, in 1999, the UK Government released the first hospital death rates for England. Last year, a decade later, a new boundary was crossed when the Government announced publication of death rates for every hospital on the National Health Service (NHS) Choices website. 60 years after it was founded, NHS patients could at last find out what their US cousins had known for years: how likely they were to leave hospital alive.

Death rates are used in many countries to measure quality of care; they are also used globally to compare the performance of countries. But some argue that they paint too crude a picture and should be replaced with other outcome measures, such as morbidity and disability. How times change. In the early 1990s, anyone who had the temerity to question variations in outcomes risked attracting the attention of m'learned friends. Today, we seek more sophisticated and accurate measures, the better to identify those variations.

The publication of death rates changed the terms of the debate. But as quality measures they never really cut the mustard. Roger Boyle, the UK Government's National Director for Coronary Heart Disease, explained why years ago. He described his experience with his father who was a high-risk heart patient: "I knew the outcomes for all the heart surgeons in the area but I did not choose the one with the lowest mortality. I went to the surgeon who had most experience in dealing with my father's particular problem."

This is the challenge—how to put the average patient (and their family) in the position of the expert—and raise standards at the same time. We need measures that have credibility with practitioners and intelligibility for the rest of us. Death rates may have served their purpose, but we should be cautious before jettisoning simple measures.

Jeremy Laurance

J.Laurance@independent.co.uk

Lunch with *The Lancet*

Carla Boutin-Foster

An hour or so in the company of Professor Boutin-Foster leaves you feeling optimistic about at least one of society's ills. As Director of the Center of Excellence in Disparities Research and Community Engagement (CEDREC) at Weill Cornell Medical College in New York, USA, Boutin-Foster works to improve health care for underprivileged minorities. She speaks with such passion about her work that you start to believe the relation between socioeconomic status and health really can be broken.

The daughter of Haitian immigrants, Boutin-Foster grew up in a single-parent household in Queens, New York. Today, immaculately dressed, she meets me for lunch in an elegant French restaurant opposite the glass-fronted tower in which she works on Manhattan's Upper East Side. She has risen to the top to help those at the bottom. "It's very personal. I want to do something about it. These are my grandparents, my parents, you know, it's me." Between spoonfuls of fish and saffron soup she tells me about the plans and projects of CEDREC—established in January with a US\$8 million grant from the US National Institutes of Health. "It's all about understanding the problems, and solutions, from the community's perspective and using that to inform research."

Problems are aplenty in the largely African-American communities of the South Bronx and Harlem, where the research is focused. Rates of drug addiction, HIV infection, depression, and violence are high. Boutin-Foster would like to address them all, but CEDREC is starting with the major killers: cardiovascular disease and cancer. One initial project involves using local barbershops to recruit older African-American men for blood pressure and colorectal cancer screening. Similar projects, such as using nail salons to recruit women for breast cancer screening and churches and community centres for weight-loss programmes, are likely in the future.

Health disparities do not simply come down to whether people have health insurance or not. In countries with free health care socioeconomic correlates to health still exist. Boutin-Foster is thus not worried that Barack Obama's freshly signed health-care bill will soon be putting her out of a job—although she says she would be happy if it did. Much of the disparity, she insists, is down to people's lack of self-value—with low income comes low self-esteem and low interest in personal health. Divorcing individuals' perceptions of self-worth from the reality of their economic status is a tough call, perhaps toughest of all in the USA. But, through engineering community projects that provide self-motivation for health, that is precisely Boutin-Foster's goal. The message she imparts: "this is just a situation, it doesn't define you."



Ruth Williams

ruth.williams@absw.org.uk