of immunological suppression such as CMV and Pneumocystis carinii.

Between the rich world and the poor world there is already a huge energy gap, a huge consumption and pollution gap, the vital communication chasm gapes wider, and now there are two HIV diseases. In the rich world, AIDS is now a chronic disease affecting a minority still separated by their sexual mores and chaotic drug use from the rest of society, and it can be held at bay for long periods, albeit with costly combinations of toxic drugs. In Zambia, it is a sub-acute disease affecting a fifth or more of the people and afflicting everyone by its impact upon the society of today and the children of tomorrow. Amidst this poverty, this squalor, the multiple infections and infestations, a positive HIV test is a death sentence to be executed within 3–5 years. There is a dignity, there is too a fatalism – when there is no hope ... just cope.

Note
The above is the personal view of the author and not necessarily government policy.

Yours faithfully
Professor Peter Sims
c/o Foreign and Commonwealth Office,
King Charles Street,
London SW1A 2AH

'Syndromes' and reasons not to do a project

Sirs,

We have all mixed feelings before starting a project – and have at least temporarily tried to escape them. I think this painstaking decision-making process consists of a set of 'syndromes'. One or probably several of the 15 syndromes below have sometimes hit us all. To have suffered from them is a normal part in the life of any scientist.

The syndrome might be based on reality – even be factual – but may also form a hidden or overt excuse to avoid challenges. The natural history varies – cure, remitting or chronic.

You may use this to diagnose the project syndrome profile of yourself and others and use it for prevention and treatment.

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technocratism</td>
<td>I must have equipment A before I can go further</td>
</tr>
<tr>
<td>Hyperlogism</td>
<td>I must have data A analysed before I take on data B</td>
</tr>
<tr>
<td>Analysm</td>
<td>I want to go more in depth with problem A before I can write something meaningful</td>
</tr>
<tr>
<td>Sequentialism</td>
<td>I must finish project A before I start with project B</td>
</tr>
<tr>
<td>Escapism</td>
<td>I shall take on project A when I have more time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monetarism</td>
<td>I must have funding before I start project A</td>
</tr>
<tr>
<td>Corruptionism</td>
<td>I really want to do the scientifically more important project A, but will give priority to project B because it is easier to get funded</td>
</tr>
<tr>
<td>Librarianism</td>
<td>I must read more before I involve myself in project A</td>
</tr>
<tr>
<td>Educationalism</td>
<td>I must have more training before I start with project A</td>
</tr>
<tr>
<td>Administration</td>
<td>Instead of engaging myself in my main task, project A, I will take on project B, because somebody has to do project B</td>
</tr>
<tr>
<td>Oralism</td>
<td>I will present some results from project A at the A congress, but I see no possibility to produce a manuscript for a scientific journal</td>
</tr>
<tr>
<td>Citationism</td>
<td>I will try to avoid the extra work needed to publish in the well-renowned journal A, and will therefore send my manuscript to the less prestigious journal B</td>
</tr>
<tr>
<td>Healthism</td>
<td>I must feel a little better before I start with project A</td>
</tr>
<tr>
<td>Moralism</td>
<td>I think it is my duty to do something to problem A even if it is not innovative</td>
</tr>
<tr>
<td>Familism</td>
<td>I must see my wife/husband and my children more, otherwise I will be a poor husband/wife or parent</td>
</tr>
</tbody>
</table>

Yours faithfully
Erik Allander
Professor
Karolinska Institute,
Department of Social Medicine, M96,
WHO Collaborating Centre for the Epidemiology of Rheumatic Conditions,
Huddinge University Hospital,
S-141 86 Huddinge,
Sweden

NHS performance guides: raising the standard – indirectly?

Sirs,

The NHS performance guides are now published annually to 'help you and your family doctor decide where you can go to get the best services'. The guides award hospitals star ratings for a number of simple 'performance' measures. Like star ratings for hotels, these have been awarded on the basis of percentages: e.g. over 90 per cent in a given measure attracts five stars. Unlike star ratings for hotels, mostly awarded on 'provision' (e.g. proportion of rooms with private bath and WC), hospitals have been awarded stars on 'performance', e.g. proportion of waiting list patients admitted within 12 months.

The performance tables present a very limited picture of the standard of care by NHS hospitals and doctors; other health professionals and hospital managers have ample grounds for criticizing their presentation, emphasis and content under that
guise. Thirty-six of 43 hospital performance measures (84 per cent) included in the table are waiting list measures, which gives the performance tables a very strong bias towards the perennial waiting list issue, particularly when the media cherishes the even simpler statistics of averages of averages and constructs league tables of average star ratings. It should not be forgotten that waiting lists are almost wholly for relatively few conditions in the surgical specialties and that over half of hospital admissions are urgent. Simple measures such as the proportion of patients seen within 12 months certainly can inform hospital managers, health service planners, referring general practitioners (GPs), patients and the public at large, because in the past surprisingly few were aware of or had ready access to even quite simple statistics. Furthermore, describing such simple statistics as performance measures may lead to increasing the proportions seen within 12 months, and this in turn may be equated with raising standards – in one aspect of NHS activity. However, even the statistically unsophisticated appreciate that there are other ways of presenting numerical information, various caveats and often several explanations for ‘good’ results, hence the favourite quotation ‘lies, damned lies and statistics’.

As 84 per cent of a hospital’s possible performance rating is based on waiting list data the guide might be more appropriately termed ‘A guide to NHS hospital waiting times and other statistics’. The guide might then be read as a sequel to the work of John Yates, *Inter-authority comparisons and consultancy* and the College of Health, in publishing wide differences in waiting lists between hospitals. At the time Yates listed the numbers of patients waiting by hospital, the information was available only to those who ‘knew the system’ and had time and patience to flush the information out. The waiting list information, although simple, displayed wide disparities, and as such was useful to those individual patients who were in a position to exercise choice and seek referral to hospitals other than their own district general hospital.

Comparable information is less useful to the individual patient now, because, perversely, the ‘internal market’ allows less choice at the margin because the patient’s health authority or the patient’s ‘fund-holding’ GP will have already established a contract with a provider. The guide, although addressed at the patient and the public, must in practice be addressed at the ‘purchasers’, to encourage adjustment at the margin, whereby ‘good’ performance one year may be rewarded by more contracts and more referrals next year. However, even at the contracting level the scope for adjustment is limited: relatively few ‘purchasers’ would have the realistic option of moving contracts from, for example, St James Hospital, Leeds, 129 stars (on 43 items, average 3.0 stars per item) to, for example, Cheltenham General, 183 stars (on 43 items, average 4.3 stars per item).

The emphasis in the text on ‘quality of service’, ‘best place for your treatment’ and the ‘award of charter marks’ all present a rather false impression of what underpins the star ratings. Whereas patients certainly value shorter waiting lists, they are not so unsophisticated as to wish to use the simplified waiting statistic alone in judging quality of hospital care by comparison with, for example, successful surgery, low wound infection rate, low complication rate and well-planned admission and discharge. The few non-waiting list measures included are similarly oversimplified and similarly only loosely related to quality. For example, stars have been awarded for the proportions of certain surgical procedures undertaken as ‘day cases’. Patients may prefer, all other things being equal, to be ‘day cases’ rather than in-patients, but few would judge the quality of surgical care solely on whether or not they were allowed home before nightfall. Stars have been awarded also for the proportion of patients ‘triaged’ within five minutes of arrival in Accident and Emergency, but what constitutes triage? A full assessment by a suitably qualified person is for many who attend Accident and Emergency the definitive assessment.

One is tempted to deduce that many of the statistics included in these performance tables are recorded more because they are measurable than because they represent quality. Another set of statistics, such as ‘case fatality’ would be far more powerful in comparing quality of care between hospitals. Next, such more rigorous measures of NHS output would need to be standardized or adjusted for age, sex, case-mix, etc., so that like is compared with like, and so that a hospital is not unfairly ranked simply because its case-load is old and sick. However, often standardization tidies the finer detail without replacing the important outliers. There are many historical examples where relatively simple statistics have recorded poor performance with eminently plausible explanations that had hitherto been ignored by those who failed to make comparisons with others or with ‘standards’, and institutions and practitioners implicated in poor performance have been able to improve. Many would argue that, as the information conveyed in such outcome measures is highly sensitive and statistical literacy generally so poor, these comparisons are best left in the domain of the confidential enquiry, peer review and audit. This is an issue that has been discussed and debated elsewhere. If these more rigorous measures of clinical outcome are regarded as too sensitive for public release, one might then be tempted to deduce that the present performance tables may be an ingenious smoke screen under which ‘real’ performance data are compared by the relevant professional bodies (for example, the Royal Colleges audit groups or the Clinical Standards Advisory Group).

The most defensible justification for the present performance guides and perhaps for the present charter standards themselves is that the simple and measurable, such as the proportion of patients admitted within 12 months, might be related to the clinically important and more sensitive outcomes. The simple can of course be misplaced, if, for example, the award of a charter mark in mental health for ‘establishing community consultation and six public meetings per year’ were followed by only one schizophrenic patient, inadequately supervised and controlled ‘in the community’, running amok
with a machine gun. Nevertheless, there are perhaps examples that suggest that attention to performance in the apparently superficial may be associated with attention to performance in the important. The Clinical Standards Advisory Group study of urgent admissions to hospital found a statistically significant association between time to admit and 28-day case fatality.\(^2\) The charter standard, which followed that study, to admit within two hours of arrival, could usefully improve patient care and clinical outcome.

Doctors, other health professionals and hospital managers could use the present performance guides and the associated charter standards not as ends in themselves, which might act as a distraction from more important objectives of patient care, but as a means to improving patient care in its fullest sense.

**References**


**Rheumatic fever**

Sirs,

Rheumatic fever is a major cause of acquired heart disease in children and young adults throughout the developing world.\(^1\) Previous studies have drawn attention to the worrying increase in prevalence of rheumatic heart disease in the African continent.\(^2,3\) With respect to Asia, a recent report suggests that the prevalence in a developing Asian country such as in Malaysia is also high: 20.6 per cent of cardiology cases encountered in the largest hospital in Malaysia were rheumatic heart disease cases.\(^4\) The reasons for this high prevalence in Malaysia are not immediately obvious but may be related to undertreatment of streptococcal sore throats by medical practitioners. On the other hand, it may simply be due to the lack of patient awareness of the need to seek prompt medical attention for severe bacterial pharyngitis. We have therefore conducted a questionnaire survey of both Malaysian medical practitioners and the public to investigate this.

The questionnaire for the survey was distributed to a group of 10-year-old schoolchildren at a primary school (A), \(n = 30\), a group of cardiology out-patient attenders (B), \(n = 30\), and a group of medical officers in a large university teaching hospital (C), \(n = 30\), in Kuala Lumpur, Malaysia. The multiple choice questionnaire for groups A and B consisted of nine stem items, addressing frequency of sore throats, ideas about the causes of sore throats and the relationship to heart disease was designed to be completed in a matter of minutes by the respondent, who remained anonymous. The questionnaires completed by group C consisted of only three stem items assessing their response to a case history of bacterial pharyngitis.

Questionnaires were returned by all participants. The majority of participants in group A (74 per cent) and 48 per cent of group B suffered with pharyngitis less than five times a year. In response to the question ‘What did you do each time you had a sore throat?’, 5 per cent of group A favoured seeing...