

(*Clin Med JRCPL*, July/August 2002, pp287–9). There is an increasing 'diagnostic compression' in the early stages after presentation, especially with respect to 'rule-out' strategies such as chest pain observation units¹. In addition, length of stay and duration of treatment are becoming shorter for many conditions, especially toxicology. These factors result in many patients potentially being processed within 12 hours. The economics of observational medicine, in terms of direct costs, and risk-management savings, suggest that trusts stand to gain a definite advantage from implementing observation-unit medicine².

As a result, the barriers between emergency medicine and acute medicine are becoming increasingly blurred. In the light of the Department of Health document *Reforming emergency care*, those managing medical urgencies surely need to investigate novel system modifications to find solutions to the difficulties of increasing supply/demand disparity and increasing emphasis on delivery of quality acute care.

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Consultant careers

Editor – Many plaudits to Nicholas Morrell and Carol Black for their editorial (*Clin Med JRCPL* May/June 2002, pp185–7) and for bringing into focus the important issue of the need for flexibility and diversity for consultants as they progress through their careers.

Consultant career progression has developed with little formal structure, guidance and support. Furthermore, opportunities for diversification have been largely restricted to medical research, teaching, or management.

Eight years into my post as a consultant rheumatologist, I felt the need for a further challenge and decided to study law. Using my own initiative, time and money, I

undertook an LLB (Honours) course by distance learning. Colleagues hearing of my venture were surprised, and whilst too polite to say so directly, either felt that this was a waste of time or suspected some ulterior motive such as seeking a change of career!

Having completed the course, I acknowledge that it was hard work and intellectually challenging. It required extreme discipline to submit coursework on time. It was also a chastening experience to sit 11 three-and-a-half hour examinations over the four-year period and to write a dissertation (again!). If this experience taught me nothing else, then at least I have revisited what it is to be an undergraduate and hope that I am more sympathetic to my own medical students.

Consultants should be encouraged to diversify. A study of philosophy, literature, art or music may enhance medical practice. The humanities may promote empathy and communication skills by stimulating creative thought and may foster a more enlightened approach towards patients and colleagues. I believe that these attitudes will positively impact upon medical care, job satisfaction and junior colleagues who view consultants as their role models.

I hope that the new appraisal system, under the aegis of clinical governance, will promote a more structured progression for consultants' careers, and wider opportunities for personal development. This is a cause that deserves to be championed by the College.

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Hospital episode statistics: time for clinicians to get involved?

We do not agree with Williams and Mann¹ that hospital episode statistics (HES) quality is uniformly 'inadequate for the task' and consider that their paper neglects to document the improvements in data quality in recent years. Both English HES, which started in 1987, and Welsh HES (known as PEDW), which began in 1990, experienced initial problems of incomplete admission capture, but studies relating to more recent years show that the accuracy of

HES records has improved^{2,3}. Work carried out for the Bristol Inquiry concluded that HES data were of sufficient quality to carry out national comparisons⁴. In particular, HES appeared to record some 99% of 30-day post-operative deaths in hospital⁵. Information on HES quality is now readily available – such as the Data Quality Indicator, a percentage summary figure comprising 13 component indicators, which is available at Trust level⁶. Williams and Mann's observations are based on published literature on data validity but publication bias is likely to operate with data of adequate quality being deemed less worthy of mention.

Problems with data quality are often not uniform but vary by coding field, clinical area, Trust or occasionally region and by year. The approximate agreements in diagnostic coding in one study⁷ were quoted as 55% and 72% in two hospitals for a random assortment of diagnoses, but the paper goes on to document agreements of 86% and 91% for specific diagnoses such as asthma. As Williams and Mann highlight, fewer secondary diagnoses and complications are recorded in the UK than in the US, but this is not a good comparison. There is a financial incentive in the US to record co-morbidities more thoroughly, as this may place the patient in a more severe diagnosis related group and bring in more income⁸. Difficulties with comparing data between hospitals or over time may also occur due to variations in diagnostic practices between clinicians, which are independent of the quality of clinical coding⁹.

Quality problems are not confined to hospital data. One quoted study¹⁰ compared cancer admissions with a Cancer Registry but cancer registries are particularly prone to incomplete capture so they cannot be regarded as a gold standard. Death certification does not always agree well with post mortem findings¹¹, while in the Framingham study, the death certificate attributed 24% more deaths to coronary heart disease than a review panel of three physicians¹². In addition, some true underlying causes of death may be under-represented or absent from death certificates¹³.

We agree that a number of issues for HES need to be addressed such as the use of the consultant episode as the building block of

the data set. Record linkage to identify readmissions or across datasets remains difficult despite the introduction of the NHS number into HES in 1997, as the NHS number remains poorly filled in (L Shurlock, personal communication). However, there is tremendous potential for HES if used carefully¹⁴ and the increased involvement of clinicians in the local collection, validation, and use of HES is essential to improve quality further.

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In response

We are grateful to Dr Bottle and colleagues for their comments on our paper and the opportunity to reply. We stand by our belief that the quality of HES data at present is inadequate for the tasks for which it is now being used, particularly performance monitoring and, in the future, underpinning the consultant contract. We agree that there must be examples of good practice but these are not recorded in the literature and the clearly documented examples of failures of the data are of concern.

The essence of our argument is that as HES data were devised for managerial purposes but are now being used to monitor clinical practice, it is essential that clinicians become involved in the processes of data collection and, in particular, in validation. Data quality indicators do not assess the clinical validity of the data and it is not acceptable to have variations in diagnostic practices between clinicians if the resulting data are to be compared across sites. There is a need for standardisation of the clinical as well as the organisational and technical aspects of clinical coding.

We certainly agree that there is tremendous potential for HES, if used carefully, and have been in discussion with the HES office regarding the expansion of HES data items and the opportunities for greater clinical engagement in the process. We hope that this debate will catalyse the interest of our colleagues.

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