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Diastolic blood pressure and CHD deaths: a J curve relation?

The traditional view that the lower the blood pressure the lower will be the total mortality and the fewer the deaths from myocardial infarction and stroke seems to have come mainly from studies of people at low risk of coronary heart disease. Among more heterogeneous populations low diastolic blood pressure may be associated with an excess of cardiac events. On p 385 D'Agostino *et al* question whether a J curve relation between blood pressure and death from coronary heart disease is confined to high risk subjects with myocardial infarction. Using 34 years of follow up data from the Framingham study, they found that there was no significant relation between diastolic or systolic blood pressure and death from non-cardiovascular disease. For death from coronary heart disease there was an increasing continuous relation with both diastolic and systolic blood pressure in low risk subjects. By contrast, in a high risk group with myocardial infarction there was a U curve relation between diastolic blood pressure and death from coronary heart disease which seemed independent of treatment, age, sex, other coronary heart disease risk factors, ill health, and left ventricular function.

Measures of performance in Scottish maternity hospitals

As a result of an increasing emphasis on measures of performance the NHS has issued crude indicators of resource use. These measures take no account of case mix despite the known association between outcomes and aspects of the patient's demography, case history, and the severity of the current condition. The need to take account of such considerations is shown by Leyland *et al*, who analysed Scottish maternity hospitals (p 389), for which a national system of records provides information on about 98% of births and a three tier system of specialist care means that patients are assigned to hospitals partly on the basis of known or envisaged problems. Over half a million computerised records of birth were used to develop statistical models that make allowance for the characteristics of mothers when comparing the performance of a hospital with that of others or performance in Scotland. The models make it possible to identify patient groups within hospitals in which outcomes differ from those in the rest of the country.

Oral rehydration in children with diarrhoea

Oral rehydration is underused for treating children with diarrhoea and dehydration in developed countries, even though it has been shown to be cheap, simple, safe, and effective. In a randomised controlled trial in Australia, Mackenzie and Barnes (p 393) show that at least 85% of children who would traditionally have been rehydrated with intravenous fluids could be successfully treated with oral fluids. Many doctors believe oral rehydration is more time consuming than the intravenous method. The authors suggest that using a nasogastric tube can save time, and although the tube may be uncomfortable, it is less distressing than an intravenous line. Many children who received oral therapy were rehydrated over six hours, and it may be possible to treat some children as outpatients or short stay inpatients.

Changing clinical practice

The success of formal audit of clinical practice in achieving better standards of health care assumes the ability of information feedback to change clinical practice. On p 398 Mugford *et al* describe the evidence available for this assumption in their review of 36 research papers in which information derived from routine health data systems was used to attempt change in clinical practice. They conclude that the use of such information requires critical evaluation and question whether the considerable resources invested in clinical hospital computer systems are being used to best effect.

Computers in audit

Audit is now a reality of medical practice and an activity in which computers might be thought to have a major role. On p 403 Crombie and Davies argue that the problems facing audit cannot be solved by the development of computerised data collection systems as computers can help in only two stages of audit—namely, data processing and analysis. Recasting the audit cycle, they emphasise how decisions taken at one stage can affect those already taken and use a hypothetical example of an audit in a hospice to illustrate just how distant routine data collection is from the audit process.

The health service and the general election

More than three years after the NHS review the government is on the defensive about alleged underspending on the NHS, and the public is increasingly aware that some of the NHS reforms involve unfairness. On p 405 Calum Paton discusses the economic logic and political consequences—likely to be good for the Labour party as long as health is a salient issue in the election—and the future of the NHS reforms. He lists four criteria to be included in a successful national health service: adherence to the principle that money follows the patient but in a manner beneficial to the patient; consistency in types of contract placed with providers by general practitioners who hold their own budgets and purchasing health authorities; a citizen's charter; and a planning system that reconciles incentives for providers to attract business with national priorities based on equity and effectiveness.