In New York state, adjusted mortality rates for cardiac surgery have been publicly disseminated since 1990. Although some evidence exists that this programme has resulted in a lower than expected cardiac surgery mortality rate for the state, what is not clear is if public dissemination of the information was necessary. Few patients who have bypass surgery are aware of the publicly available mortality rates of their surgeon or hospital. Even when they do know the rates, other factors may be more important. The hospital chosen by Bill Clinton for coronary bypass surgery, for example, had the highest mortality rate for this procedure in New York state in 2001, the most recent results available to Mr Clinton at the time of his surgery. For non-cardiac procedures, most hospitals do not have sufficient case loads to compare reliably mortality at the individual hospital (let alone surgeon) level.

Publication of mortality audits in this setting serves little purpose—other than, perhaps, to create a false sense of doing something to improve quality. In fact, the underlying assumption of report card programmes may be misguided; clinically significant errors are committed at all institutions and by all surgeons, not just by the outliers with poor results. To build a framework for trust, the development and systematic adoption of effective methods to minimise errors for every patient must be a priority of the entire surgical community.

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Global functions at the World Health Organization

WHO must reassert its role in integrating, coordinating, and advancing the worldwide agenda on health

Delegates from the World Health Organization’s 191 member states convene in Geneva this week to review WHO’s proposed 2006-7 budget and to prioritise the organisation’s core functions. This is a good time, therefore, to consider the optimal balance that WHO could strike between its global role in advocacy, surveillance, standard setting, and research as compared with its more operational work in specific countries and regions.

Accelerating globalisation has changed dramatically the context in which WHO works, offering both opportunities and challenges for health and its distribution. The transfer of knowledge and technology and the sharing of best practices, treatments, and health strategies provide real benefits to previously unserved populations. All countries can benefit from international standards for health and sustained advocacy on their behalf. Globalisation can also benefit health indirectly, promoting gender equality and human rights1 and better prospects for trade, information technology, and economic growth.

But globalisation has also hastened the spread of infectious diseases. Moreover, aspects of global business have promoted unhealthy behaviours, such as eating unhealthy diets and using tobacco. And a major concern with globalisation remains inequalities in health2 and other economic and social indicators, both within and among countries.

WHO’s work and functions are defined by its constitution and can be categorised as global, national, and intranational. Worldwide, WHO can set standards, develop and run international initiatives, provide professional management, manage financial transfers, and build scientific research capacity. It can also promote public health goods for the benefit of all. These goods include leadership and advocacy for health, instruments to protect bioethics and human rights, methods for disease surveillance, and application of standards. Examples include WHO’s leadership in developing the International Code of Marketing of Breastmilk Substitutes and the Framework Convention on Tobacco Control.

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Pluralism in international health

The framework of international health is no longer dominated by a few organisations, and it now involves numerous players. Health debates regularly arise at gatherings of the Group of Eight Industrialised Nations (G8) and other multilateral meetings. The World Economic Forum has hosted debates on health issues, ranging from vaccines and HIV/AIDS to tobacco and obesity. A private and not-for-profit sector has become an important force in international health as new organisations such as the Global Fund for Aids, Malaria and TB; the Bill and Melinda Gates Foundation; and pharmaceutical companies play larger roles. More than 50 private-public partnerships, such as the Global Alliance for Vaccines and Immunization, have been established to tackle specific challenges. International non-governmental organisations, including among others Médecins Sans Frontières, Oxfam, and CARE, now work together in health emergencies and disasters and take part in policy development, and in the past two decades the World Bank has had a greater role in health development.7

These changes have brought many benefits for health worldwide. This pluralism, however, has also led to an increasingly fragmented, reactive, and disparate agenda for international health that needs new leadership to convene and coordinate. In this context WHO has a unique coordinating function. Its constitution gives it alone the authority to develop and implement worldwide standards and initiatives to improve health.

WHO shifts to operational work

But now, despite a growing consensus calling for global solutions, current thinking at WHO reflects a different emphasis. To overcome the glacial pace of drug delivery to patients with AIDS and tuberculosis, WHO’s director-general, Dr Lee Jong-wook, is focusing on shifting staff to countries so that they can work to enhance the distribution of treatments and build up local offices. WHO’s “3 by 5” initiative, an admirable effort to increase access to antiretroviral medicines for three million people with HIV in less developed countries by 2005, exemplifies this approach.

It is hard to fault the intent behind the 3 by 5 initiative, but it does represent a marked shift away from WHO’s broad based mandate and towards strategies for treatment rather than for health promotion. It emphasises the importance of operational work within countries, though this work is already being undertaken by many others.

Similarly, WHO’s proposed budget for 2006-7 focuses on health interventions within countries and reinforces a shift in resources from headquarters to the regions and to WHO’s presence in countries.10 This shift implies that WHO will become more operational and less global.

A mandate for leadership

A notable exception to these trends is the WHO Commission on Social Determinants of Health,11 which brings together academics and practitioners to review knowledge and to promote policies to reduce global health inequalities. The commission is fulfilling WHO’s agenda-setting role by identifying this issue as a priority for international cooperation and national action.

Future success in implementing WHO’s global mandate will depend on considerable investments in internal expertise related to, for example, the Codex Alimentarius Commission, in which WHO and the UN Food and Agriculture Organization will establish international food standards; the crucial next steps in the Framework Convention on Tobacco Control;9 the impacts on health of trade agreements; and efforts to implement the Global Strategy on Diet and Physical Activity.

These areas of work and others urgently need strengthening, and WHO must reassert its role in integrating, coordinating, and advancing the worldwide agenda on health. In the months ahead the executive board must discuss, openly and rigorously, WHO’s core functions and mandate. The global health community will eagerly await its conclusions.

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Competing interests: JR worked at the World Bank until 2004. DY is funded by Novo Nordisk A/S to carry out chronic disease prevention research, and is a past executive director of WHO.

This is an observational study and may be subject to residual confounding. However, we think that enough concerns exist to warrant a reconsideration of the cardiovascular safety of the other selective non-steroidal anti-inflammatory drugs (NSAIDs).

What this study adds

Rofecoxib, diclofenac, and ibuprofen were associated with a higher risk of myocardial infarction; no evidence of a cardioprotective effect for naproxen was found.

The increased risk with rofecoxib in the VIGOR study was genuine; the toxicity of conventional NSAIDs and newer selective NSAIDs is also of concern.

No clinically important interactions occurred between any NSAID and either aspirin or coronary heart disease.

Corrections and clarifications

Self harm was misrepresented (again)
We inadvertently mangled the first name of this first author of this letter by Naveen Kapur and Jayne Cooper (BMJ 2005;330:1029-30, 30 Apr). Our apologies.

Global functions at the World Health Organization
We slipped up in making some late changes to this editorial by Jennifer Prab Ruger and Derek Yach (BMJ 2005;330:1099-100, 14 May). The competing interests for the first author should have read: "Dr Ruger worked previously at the World Bank and served on the health and development satellite of former Director-General Brundtland's transition team."

Obituary: Archibald John Ogg
When we scanned the original obituary into our system, we failed to notice that the initial O in the name of one of the contributors (J K Oates) got corrupted and appeared as a "D" (BMJ 2005;330:968, 25 Apr).

The hazards of good memory
In this Personal View by Mukalii Raji, an editing error led to the attribution of Alzheimer's disease to the reviewer of a book on the disease rather than to the author of the book (BMJ 2005;330:515, 16 Apr). The sentence that began "In a book review Dr Peter Whitehouse, who also happened to have Alzheimer's disease, said" should have read: "In a review of a book by an author with Alzheimer's disease (Thomas Delagio's Losing My Mind: An Intimate Look at Life with Alzheimer's), Dr Peter Whitehouse said . . ."

Why clinicians are natural bayesians
It seems that Thomas Bayes was a presbyterian minister—not a vicar, as was stated in this article by Christopher J Gill and colleagues (BMJ 2005;330:1080-3, 7 May).

Minerva
Minerva mixed up her penicillins in her opening sentence of the final item of her 7 May column (BMJ 2005;330:1094). She referred to flucloxacillin as a broad spectrum antibiotic; it is in fact a penicillinase-resistant penicillin.

Excess coronary heart disease in South Asians in the United Kingdom
The authors of this editorial, Velmurugan C Kuppuswamy and Sandeep Gupta, have alerted us to two errors in their article (BMJ 2005;330:1229-34). Firstly, the third from last paragraph should have referred to the South Asian Health [not Heart] Foundation. Secondly, three authors were inadvertently omitted from reference 12: the full list of authors is Kuppuswamy V, Jiurec K, Camillie E, Sheikh AQ, Feder G, Gupta S.