Editor's preface

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At the risk of becoming, in readers' minds at least, the *Journal of Coronary Artery Bypass Grafting* (CABG), we publish here another paper on this fascinating operation. William Ghali and colleagues (page 926) report rates of in-hospital death after CABG for over 50 000 procedures performed from 1992/93 to 1995/96 at 23 Canadian hospitals. On average, 1 in 28 patients who underwent the procedure died. Thus CABG, an elective procedure for many patients, remains burdened by an extremely high death rate. Hospital-specific death rates showed enormous variation, ranging in 1995/96, for example, from a low of 1 death for every 189 procedures at one hospital to a high of 1 death for every 18 procedures at another.

Because of growing pressure in Canada and, in particular, the US to publish report cards on hospital and physician performance, the question arises as to whether these and similar data should be made available to physicians and the general public. In an accompanying editorial James Brophy and Lawrence Joseph (page 949) dispute the statistical interpretation of Ghali and colleagues, elegantly showing that much of the observed variation can be expected to occur by chance alone. Their commentary highlights new statistical techniques that may well become the standard for analysing studies that attempt to show variation in medical practice and emphasizes that, before report cards are released publicly, we must be sure that observed differences are unlikely to have arisen by chance alone.

In early 1994 it was convincingly demonstrated that maternal–fetal transmission of HIV could be prevented by giving antiretroviral drugs to the mother during pregnancy and delivery. David Patrick and colleagues (page 942) report the experience in BC, where a screening program was implemented in 1994 to identify women with HIV. The program identified 25 women with previously undiagnosed HIV infection. There is no doubt that voluntary screening for HIV among pregnant women is accepted by patients, even in areas of low prevalence of infection, and that maternal–fetal transmission (and the associated costs of treatment) can thereby be prevented.

Outpatient treatment of proximal deep vein thrombosis became possible when Levine and associates,[1] among others, showed that such man-agement (involving low-molecular-weight heparin) was as effective as traditional in-hospital management (involving unfractionated heparin). Marc Rodger and colleagues (page 931) compare the cost-effectiveness of inpatient and outpatient treatment and report that the latter is about half as expensive as the former. In the authors' practice, about 80% of patients with proximal deep vein thrombosis would be eligible for the outpatient treatment.

Researchers at the Hospital for Sick Children broke their contract with a private drug company funding their work when they released research findings without the company's authorization. Miriam Shuchman provides a fascinating review of what became a nightmare for the researchers (page 983), and Bob Phillips and John Hoey examine this issue and its implications (page 955).

Reference

1. Levine M, Gent M, Hirsh J, LeClerc J, Anderson DR, Weitz J, et al. A comparison of low molecular weight heparin administered primarily at home with unfractionated heparin administered in the hospital for proximal deep vein thrombosis. *N Engl J Med* 1996;334(11):677-81.