

Population-based cohort study of variation in the use of emergency cholecystectomy for benign gallbladder diseases

CholeS Study Group, West Midlands Research Collaborative*

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Background: The aims of this prospective population-based cohort study were to identify the patient and hospital characteristics associated with emergency cholecystectomy, and the influences of these in determining variations between hospitals.

Methods: Data were collected for consecutive patients undergoing cholecystectomy in acute UK and Irish hospitals between 1 March and 1 May 2014. Potential explanatory variables influencing the performance of emergency cholecystectomy were analysed by means of multilevel, multivariable logistic regression modelling using a two-level hierarchical structure with patients (level 1) nested within hospitals (level 2).

Results: Data were collected on 4744 cholecystectomies from 165 hospitals. Increasing age, lower ASA fitness grade, biliary colic, the need for further imaging (magnetic retrograde cholangiopancreatography), endoscopic interventions (endoscopic retrograde cholangiopancreatography) and admission to a non-biliary centre significantly reduced the likelihood of an emergency cholecystectomy being performed. The multilevel model was used to calculate the probability of receiving an emergency cholecystectomy for a woman aged 40 years or over with an ASA grade of I or II and a BMI of at least 25.0 kg/m², who presented with acute cholecystitis with an ultrasound scan showing a thick-walled gallbladder and a normal common bile duct. The mean predicted probability of receiving an emergency cholecystectomy was 0.52 (95 per cent c.i. 0.45 to 0.57). The predicted probabilities ranged from 0.02 to 0.95 across the 165 hospitals, demonstrating significant variation between hospitals.

Conclusion: Patients with similar characteristics presenting to different hospitals with acute gallbladder pathology do not receive comparable care.

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Introduction

Benign gallbladder diseases are a major global health burden^{1,2}. RCTs, meta-analyses and expert consensus support the use of emergency cholecystectomy for most patients presenting with biliary colic, acute cholecystitis or gallstone pancreatitis^{3–9}. Compared with delayed cholecystectomy following discharge after an acute admission, emergency cholecystectomy is associated with less gallbladder-specific morbidity, a shorter total length of hospital stay and similar operative morbidity^{10–15}. Despite this evidence, there is still thought to be wide variation in the management of patients presenting with acute gallbladder pathology.

Reports from Europe, Asia and North America show rates of emergency cholecystectomy ranging from 12 to 88 per cent^{16–20}. Within healthcare systems, patients with similar demographics and gallbladder pathologies also do not receive comparable care²¹. These variations may lead to avoidable morbidity, mortality and wasted resources^{22–24}. Patient and hospital factors are often cited to justify these wide differences in the use of emergency cholecystectomy. Understanding the specific patient and hospital characteristics that lead to these variations might address inconsistencies in care and improve outcomes.

Over the past 8 years, trainee-led networks in the UK have adopted a collaborative approach to deliver

population-level data collections using prospectively developed databases²⁵. Using these networks, the aims of the present study were to identify patient and hospital characteristics associated with the use of cholecystectomy following acute admission with benign biliary disease, and to see how these factors influenced variations between hospitals in the use of emergency cholecystectomy.

Methods

This prospective cohort population-based study was carried out as described previously²⁶. The protocol did not require research registration as anonymized, observational data were collected. This was confirmed by the online National Research Ethics Service decision tool (<http://www.hra-decisiontools.org.uk/research/>), and further supported by written confirmation and advice from the Research and Development Director at University Hospitals Birmingham NHS Foundation Trust, UK. The study was registered as a clinical audit or service evaluation at each participating hospital under the supervision of a named senior investigator (consultant surgeon).

Inclusion and exclusion criteria

Consecutive patients undergoing cholecystectomy for benign gallbladder diseases, including those undergoing emergency surgery, in acute UK and Irish hospitals between 1 March and 1 May 2014 were included, and data recorded using a prospectively developed database. This study analysed patients who had emergency admissions with right upper quadrant pain and symptoms; therefore, all patients with 'cholecystitis' had acute cholecystitis.

Patients were grouped according to the timing of cholecystectomy. Emergency cholecystectomy was defined as a cholecystectomy during an acute admission, and delayed cholecystectomy was defined as a planned cholecystectomy following an emergency admission with gallbladder disease. Open, laparoscopic, and laparoscopic converted to open operations were included. Patients who had a cholecystectomy for known gallbladder cancer or as a part of another surgical procedure, such as pancreaticoduodenectomy, bariatric, antireflux or transplant operations, were excluded.

Outcome measure

The primary outcome of interest was the performance of emergency cholecystectomy in comparison with delayed surgery.

Data quality

A quality assurance programme was developed²⁶. This included a detailed study protocol, a pilot phase, and a requirement for a minimum of 95 per cent data completeness at submission. Case ascertainment and data accuracy were further validated by independent investigators at selected hospitals, who checked data accuracy in approximately 20 per cent of patients. These independent investigators were not involved in the original data collection.

Explanatory variables

Patient, disease and hospital characteristics were considered as potential explanatory variables influencing the performance of emergency cholecystectomy. A full list including definitions has been published previously²⁶. Briefly, patient characteristics included here were: age, sex, ASA fitness grade (I–V) and BMI (less than 17.9 kg/m², underweight; 18.0–24.9 kg/m², normal; 25.0–29.9 kg/m², overweight; 30.0–34.9 kg/m², moderate obesity; 35.0 kg/m² and above, severe or very severe obesity). The following disease characteristics were considered: indication (biliary colic, acute cholecystitis, pancreatitis, common bile duct (CBD) stones), ultrasound findings, including gallbladder wall thickness (considered thick-walled if the wall was 2 mm or thicker) and a dilated CBD (CBD diameter 6 mm or greater), and other radiological investigations (CT, magnetic retrograde cholangiopancreatography (MRCP), endoscopic retrograde cholangiopancreatography (ERCP)).

Hospital characteristics were determined by a participating centre questionnaire and included hospital type (non-university, university-affiliated), specialist hepatobiliary centre (no, yes), acute hospital (no, yes), number of consultants within the reporting hospital performing cholecystectomy, country, number of beds within the reporting hospital (less than 100, 101–500, 501–1000, more than 1000) and the presence of an ERCP service. HPB centres were defined as hospitals offering tertiary HPB cancer resectional surgery as listed on the www.augis.org website. The hospital's policy regarding the ease of performing intraoperative cholangiography, and availability and use of dedicated emergency gallbladder operating lists, were considered. Grade of senior surgeon performing cholecystectomy, consultant presence at surgery and the consultant specialty were also recorded. Hospital volume of cholecystectomies was determined by ranking hospitals in order of increasing volume and selecting cut-off points that sorted patients into three evenly sized cohorts with low, medium and high volume.

Table 1 Patient factors in relation to performance of emergency and delayed cholecystectomy

	Emergency cholecystectomy (n = 1451)	Delayed cholecystectomy (n = 3293)
Age (years)		
< 40	441 (30.4)	859 (26.1)
40–60	510 (35.1)	1161 (35.3)
61–80	435 (30.0)	1108 (33.6)
> 80	65 (4.5)	165 (5.0)
Sex		
F	1000 (68.9)	2189 (66.5)
M	451 (31.1)	1104 (33.5)
BMI (kg/m ²)		
< 17.9	6 (0.4)	17 (0.5)
18.0–24.9	262 (18.1)	667 (20.3)
25.0–29.9	494 (34.0)	1108 (33.6)
30.0–34.9	337 (23.2)	805 (24.4)
≥ 35.0	250 (17.2)	560 (17.0)
Unknown	102 (7.0)	136 (4.1)
ASA fitness grade		
I	516 (35.6)	1127 (34.2)
II	704 (48.5)	1746 (53.0)
III	204 (14.1)	387 (11.8)
≥ IV	12 (0.8)	9 (0.3)
Unknown	15 (1.0)	24 (0.7)
Indication		
Biliary colic	295 (20.3)	955 (29.0)
Acute cholecystitis	795 (54.8)	1369 (41.6)
Pancreatitis	268 (18.5)	545 (16.6)
CBD stone	83 (5.7)	386 (11.7)
Polyp	2 (0.1)	16 (0.5)
Dyskinesia	1 (0.1)	9 (0.3)
Acalculous	6 (0.4)	11 (0.3)
Other/missing	1 (0.1)	2 (0.1)
Ultrasonography performed	1348 (92.9)	3163 (96.1)
Ultrasound findings		
Thick-walled	729 (50.2)	1412 (42.9)
CBD dilated	289 (19.9)	793 (24.1)
CT performed	290 (20.0)	680 (20.6)
MRCP performed	417 (28.7)	1319 (40.1)
ERCP performed	139 (9.6)	670 (20.3)

Values in parentheses are percentages. CBD, common bile duct; MRCP, magnetic retrograde cholangiopancreatography; ERCP, endoscopic retrograde cholangiopancreatography.

Statistical analysis

Results are reported in accordance with the STROBE statement for observational studies²⁷. Crude rates of emergency cholecystectomy for all patients at each hospital were calculated.

Descriptive statistics were obtained for all variables. The χ^2 test was used to identify differences between categorical variables. To enable exploration of between-hospital variation in the performance of emergency cholecystectomy, the data were analysed by means of multilevel, multivariable

Table 2 Hospital factors in relation to performance of emergency and delayed cholecystectomy

	Emergency cholecystectomy (n = 1451)	Delayed cholecystectomy (n = 3293)
University hospital	764 (52.7)	1378 (41.8)
Specialist HPB centre	510 (35.1)	705 (21.4)
Acute hospital	1438 (99.1)	3071 (93.3)
No. of consultants performing cholecystectomies*	9 (4–8)	8 (3–4)
Country		
England	1038 (71.5)	2696 (81.9)
Northern Ireland	53 (3.7)	98 (3.0)
Republic of Ireland	59 (4.1)	157 (4.8)
Scotland	251 (17.3)	245 (7.4)
Wales	50 (3.4)	97 (2.9)
No. of hospital beds		
≤ 100	1 (0.1)	21 (0.6)
101–500	442 (30.5)	1377 (41.8)
501–1000	697 (48.0)	1579 (48.0)
> 1000	311 (21.4)	316 (9.6)
ERCP service	1382 (95.2)	3094 (94.0)
Ease of performing IOC		
Not possible	22 (1.5)	121 (3.7)
With difficulty	212 (14.6)	722 (21.9)
With ease	1217 (83.9)	2450 (74.4)
Emergency gallbladder operating lists		
No	993 (68.4)	2225 (67.6)
<i>Ad hoc</i>	152 (10.5)	403 (12.2)
Once per week	162 (11.2)	212 (6.4)
More than once per week	138 (9.5)	292 (8.9)
Elective surgery only at hospital	6 (0.4)	161 (4.9)
Consultant specialty		
Oesophagogastric	560 (38.6)	1220 (37.0)
HPB	314 (21.6)	634 (19.3)
Colorectal	352 (24.3)	831 (25.2)
Breast	42 (2.9)	137 (4.2)
Vascular	57 (3.9)	141 (4.3)
Other	117 (8.1)	327 (9.9)
Hospital volume		
High	549 (37.8)	969 (29.4)
Medium	497 (34.3)	1141 (34.6)
Low	405 (27.9)	1183 (35.9)

Values in parentheses are percentages unless indicated otherwise; *values are median (i.q.r.). HPB, hepatopancreatobiliary; ERCP, endoscopic retrograde cholangiopancreatography; IOC, intraoperative cholangiography.

logistic regression modelling using a two-level hierarchical structure with patients at level 1, nested within hospitals at level 2. Initially a null two-level model was fitted, containing no explanatory variables, examining hospital-only effects. This model estimated the log-odds ratio (OR) of a patient receiving an emergency cholecystectomy at an 'average' hospital. The residual value was a measure of the variation at each hospital for a patient receiving an emergency cholecystectomy, calculated by subtracting the

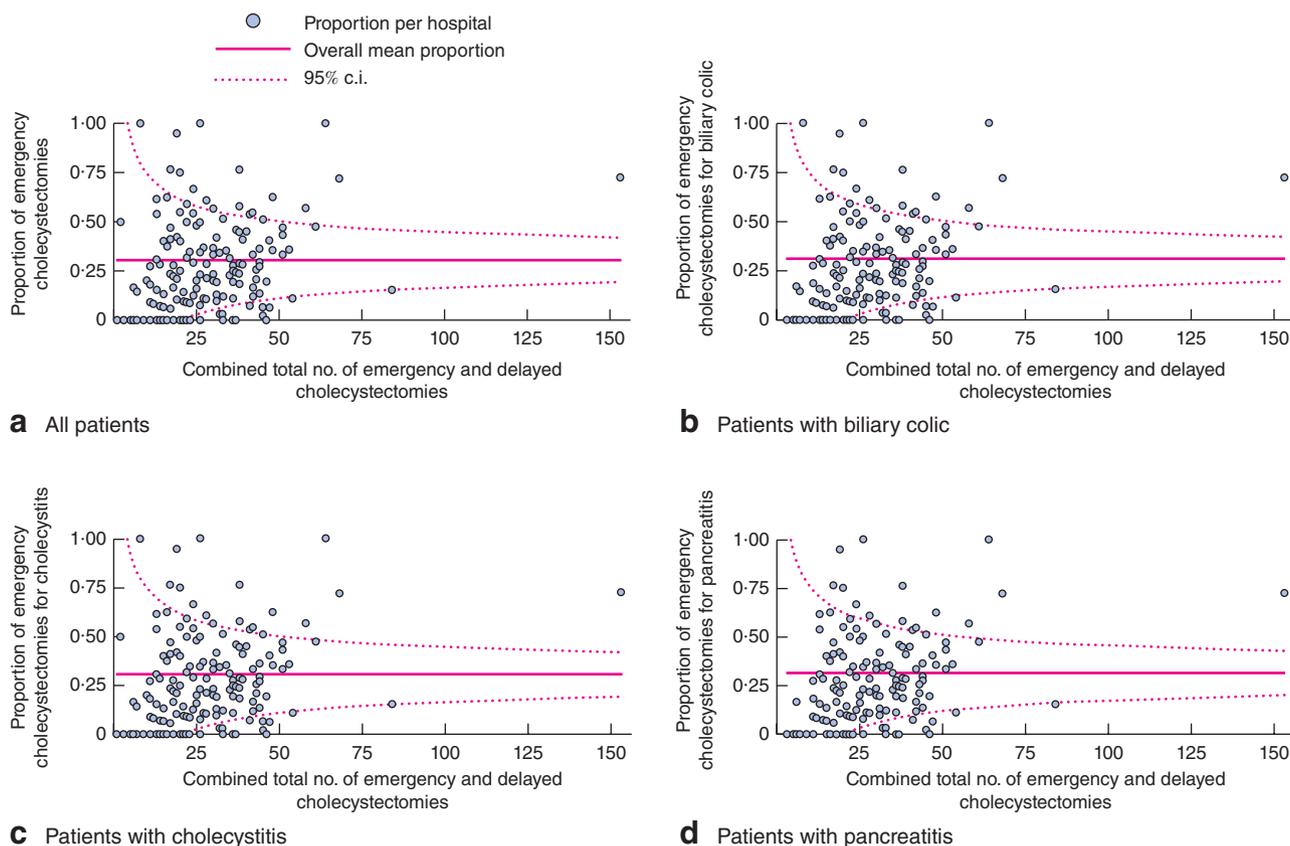


Fig. 1 Centre-specific performance of emergency cholecystectomy for **a** all patients, and those with **b** biliary colic, **c** acute cholecystitis and **d** pancreatitis

estimated log-OR for an average hospital from each hospital's estimated log-OR. The residual values were plotted in ascending order of magnitude with their respective 95 per cent confidence intervals (c.i.).

Explanatory variables were evaluated to determine whether any could explain the variation in performance of emergency cholecystectomy between hospitals, using a random intercept model. Univariable multilevel models were applied separately to each individual variable, investigating the significance of the variable as a whole and also the significance at each sublevel. No explanatory variables were excluded from the multivariable multilevel model building in order to allow for the presence of any confounders. Variable inclusion followed the forward and back Collett method for selection²⁸. All two-way interactions were assessed to ensure that there were no significant interactions in the final model. Model testing was performed using likelihood ratio tests, Wald tests, residuals and deviance plots. When the multivariable random intercept model was finalized, the variance partition coefficient was calculated. This gives a measure of the amount of

residual variation in the propensity of a patient to receive an emergency cholecystectomy that can be attributable to unobserved characteristics.

To investigate further the variations between hospitals, the random intercept model was extended to a random coefficient model, including each explanatory variable in turn, allowing the variable to vary across hospitals. Results are expressed as adjusted ORs with 95 per cent confidence intervals.

Finally, to provide a real-world interpretation of the data, the multilevel random intercept model was constructed using patient data whose true cholecystectomy surgery type (emergency or delayed) was known. Predicted probabilities were obtained using the model, based on patient characteristics for five common scenarios. The predicted probabilities obtained were grouped by patients known to have received either an emergency or delayed cholecystectomy. The mean predicted probabilities and corresponding 95 per cent confidence intervals were plotted.

All statistical methods were performed using Stata[®] version 12 (StataCorp, College Station, Texas, USA). The

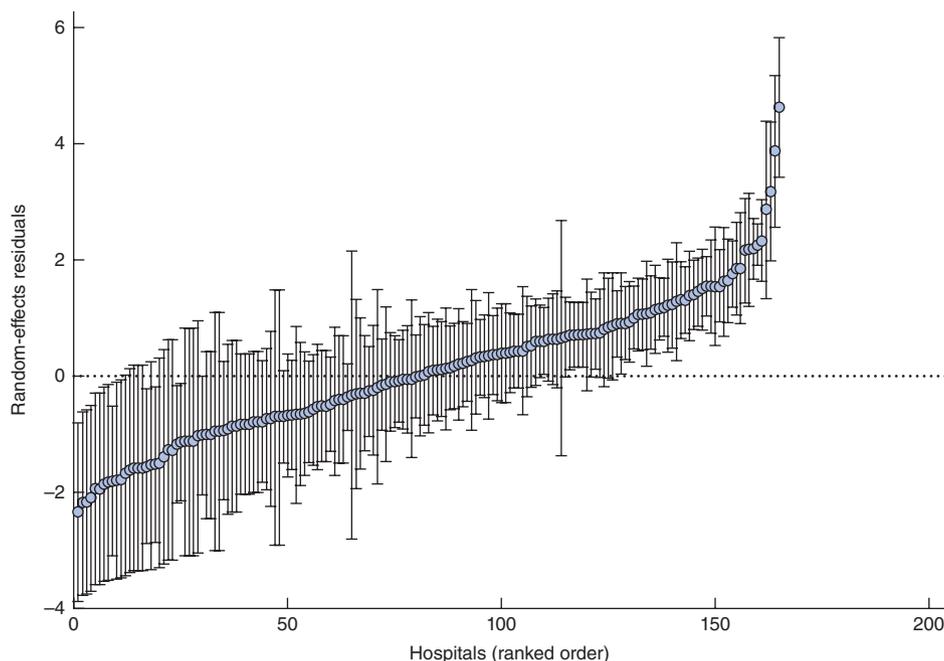


Fig. 2 Plot examining hospital effects (residuals) and corresponding 95 per cent confidence intervals

multilevel, multivariable logistic regression modelling was carried out in MLwiN version 2.14 (<http://www.cmm.bristol.ac.uk/MLwiN>).

Results

Data were collected on 8914 patients undergoing cholecystectomy from 166 hospitals, using a prospectively developed database and agreed starting date, between 1 March 2014 and 1 May 2014. Case ascertainment and accuracy of collected data were 95.2 and 99.2 per cent respectively. Data from 23.3 per cent of all patients (2077 of 8914) were checked against the original medical records by independent data validators. This equated to 11.1 per cent of all data points (64 409 of 579 410). Within the entire data set, 0.8 per cent of data were missing. Of the 8914 patients, 4744 in 165 hospitals met the inclusion criteria. Data were complete for 4698 patients and 1451 (30.9 per cent) underwent emergency cholecystectomy.

Overall demographics according to whether surgery was carried out as an emergency or delayed are shown in Table 1. Patients undergoing emergency cholecystectomy were younger than those having delayed surgery: median (i.q.r.) age 50 (35–65) versus 54 (39–67.0) years ($P < 0.001$). In addition, patients undergoing emergency cholecystectomy had higher ASA grades ($P = 0.002$), greater BMI ($P = 0.034$) and were more likely to have presented with acute cholecystitis or pancreatitis ($P < 0.001$).

Considering hospital factors, 2142 (45.2 per cent) of all cholecystectomies were performed in university-affiliated hospitals and 1215 (25.6 per cent) in specialist HPB centres (Table 2). Emergency cholecystectomies were more likely to be performed in university hospitals ($P < 0.001$), specialist HPB centres ($P < 0.001$), hospitals with more beds ($P < 0.001$), and hospitals that performed a higher volume of procedures during the study period ($P < 0.001$). Surgeons with a background in oesophagogastric or HPB surgery performed a greater proportion of the emergency operations than delayed operations (60.2 versus 56.3 per cent; $P = 0.011$).

Emergency cholecystectomy rates across hospitals

There was marked variation in the rate of emergency cholecystectomy across hospitals (mean(s.d.) 26.4(23.3) per cent (range 0–100) per cent). This remained evident even when the analysis was limited to patients with acute cholecystitis, pancreatitis or biliary colic (Fig. 1).

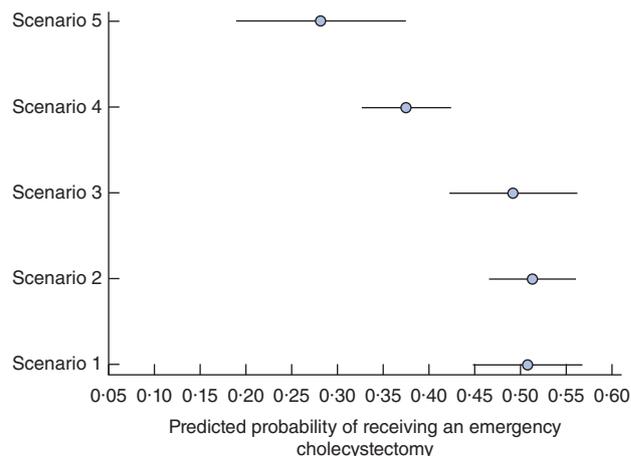
When the data were analysed by means of multi-level logistic regression modelling using a two-level hierarchical structure with 4698 patients at level 1, nested within 165 hospitals at level 2, to enable exploration of between-hospital variation in the performance of emergency cholecystectomy, the null random intercept model fitted with hospital-only effects generated estimates of a patient receiving an emergency cholecystectomy (Fig. 2).

Table 3 Multilevel random intercept logistic regression of association between patient and hospital characteristics and receipt of an emergency cholecystectomy

	Odds ratio for emergency versus delayed cholecystectomy	P
Patient factors		
Age (years)		
< 40	1.00 (reference)	
40–60	0.68 (0.56, 0.84)	< 0.001
61–80	0.54 (0.42, 0.68)	< 0.001
> 80	0.48 (0.31, 0.74)	0.001
Sex		
F	1.00 (reference)	
M	0.84 (0.70, 1.01)	0.058
BMI (kg/m ²)		
18.0–24.9	1.00 (reference)	
< 17.9	2.12 (0.78, 6.36)	0.179
25.0–29.9	1.23 (0.98, 1.54)	0.069
30.0–34.9	1.15 (0.91, 1.47)	0.247
≥ 35.0	1.12 (0.85, 1.46)	0.411
ASA fitness grade		
I	1.00 (reference)	
II	0.96 (0.79, 1.16)	0.670
III	1.43 (1.07, 1.91)	0.016
≥ IV	4.70 (1.45, 15.25)	0.010
Indication		
Biliary colic	1.00 (reference)	
Acute cholecystitis	2.23 (1.77, 2.80)	< 0.001
Pancreatitis	2.39 (1.85, 3.10)	< 0.001
CBD stone	1.12 (0.76, 1.65)	0.570
Gallbladder wall on ultrasonography		
Normal	1.00 (reference)	
Thickened	1.20 (0.99, 1.44)	0.057
CBD diameter on ultrasonography		
Normal	1.00 (reference)	
Dilated	1.30 (1.04, 1.62)	0.019
MRCP		
No	1.00 (reference)	
Yes	0.64 (0.53, 0.77)	< 0.001
ERCP		
No	1.00 (reference)	
Yes	0.49 (0.37, 0.65)	< 0.001
Hospital factors		
Specialist HPB centre		
No	1.00 (reference)	
Yes	2.67 (1.51, 4.71)	0.001
Acute hospital		
No	1.00 (reference)	
Yes	12.61 (4.04, 39.35)	< 0.001

Values in parentheses are 95 per cent confidence intervals. CBD, common bile duct; MRCP, magnetic retrograde cholangiopancreatography; ERCP, endoscopic retrograde cholangiopancreatography; HPB, hepatopancreatobiliary.

For 104 hospitals (63.0 per cent), the 95 per cent confidence interval crossed the zero line, indicating that the number of emergency cholecystectomies was not significantly different from average. In 46 hospitals (27.9 per cent), the 95 per cent confidence interval lay entirely above

**Fig. 3** Mean probability of receiving an emergency cholecystectomy, with corresponding 95 per cent confidence intervals, for patient scenarios calculated by the multilevel model

the zero line, suggesting that they performed a higher than average number of emergency cholecystectomies. In contrast, 15 hospitals (9.1 per cent) performed significantly lower numbers of emergency cholecystectomies than average. There was strong evidence of interhospital variation for having an emergency cholecystectomy (likelihood ratio statistic 848.4, $P < 0.001$).

Effect of co-variables on variation in emergency cholecystectomy rates

The random intercept model was extended to include explanatory variables (*Appendix S1*, supporting information), producing a multilevel logistic random intercept model (*Table 3*). Increasing age, biliary colic, the need for further radiological imaging and interventions, endoscopic interventions and admission to a non-specialist HPB centre all significantly reduced the likelihood of an emergency cholecystectomy being performed. Hospital volume was not a significant factor. Following the inclusion of explanatory variables in the model, the estimated between-hospital variation decreased from 2.0 to 1.8, indicating that the distribution of the explanatory variables differed across hospitals. To determine how much variation between hospitals was explained by inclusion of the variables (age, sex, ASA grade, BMI, indication, ultrasound findings, MRCP, ERCP, specialist HPB centre and acute hospital status) within this model, the variance partition coefficient was calculated. Within the model, 65 per cent of the variation was attributable to hospital characteristics.

To show how much variation was seen for a given patient across the 165 hospitals, the random intercept model was used to calculate the probability of receiving an emergency

cholecystectomy for a woman with: ASA grade I or II, BMI at least 25.0 kg/m², acute cholecystitis, ultrasound imaging showing a thick-walled gallbladder and normal CBD, and age 40 years or more (scenario 1) or less than 40 years (scenario 2). In addition, the probability of receiving an emergency cholecystectomy was predicted for three further examples: any patient aged 60 years or less with pancreatitis (scenario 3) or biliary colic requiring no further investigations (scenario 4) or requiring MRCP (scenario 5). *Fig. 3* shows the predicted probability for a patient receiving an emergency cholecystectomy together with corresponding 95 per cent confidence intervals for the five scenarios. For scenario 1, the mean predicted probability of receiving an emergency cholecystectomy was 0.52 (95 per cent c.i. 0.45 to 0.57). The predicted probabilities, however, ranged from 0.02 to 0.95 across the 165 hospitals, demonstrating significant between-hospital variation for this common clinical presentation. For the scenarios described, the need for further imaging and certain diagnoses seemed to reduce the probability of receiving an emergency cholecystectomy.

Discussion

This population-based study, using prospectively collected data, with high rates of complete data, evaluated the practice of emergency cholecystectomy for acute gallbladder diseases. There was significant variation across UK and Irish hospitals, even when different gallbladder pathologies were considered. This was due to both patient (age, certain indications, need for further radiological imaging and interventions) and hospital (admission to a specialist HPB centre) factors. Patients with similar characteristics presenting to the 165 hospitals studied did not receive similar care.

Level 1 evidence supports emergency cholecystectomy for biliary colic, acute cholecystitis and gallstone pancreatitis, based on shortened total hospital stay, a similar conversion rate to open cholecystectomy and the elimination of recurrent gallstone symptoms, resulting in less time off work than with planned delayed cholecystectomy^{3–15,29}. Although much of the supporting evidence comes from specialist institutions and enthusiasts, population-level data suggest that emergency cholecystectomy may be associated with poorer patient outcomes^{2,30}. The findings of the present population-based cohort study are consistent with those of other cohort studies demonstrating different practices and variations in emergency cholecystectomy across hospitals^{16–20}. These earlier studies suggested that variations were related to age, patient co-morbidities, surgeons' competing elective clinical

obligations, comfort with emergency laparoscopy, the availability of hospital resources and insurance status^{31–33}.

The present prospective study collected and independently validated data obtained from trainee-led networks in the UK and Ireland. This methodology is powerful when studying surgical variations^{34,35}. Variations between hospitals in the performance of emergency cholecystectomy were analysed using multilevel, multivariable logistic regression modelling. This identified both patient and hospital variables accounting for the between-hospital variation seen. The patient variables identified here (increasing age, co-morbidity and indication) seem predictable and have been noted previously²¹. The need for further radiological imaging and interventions, endoscopic interventions and hospital factors (such as admission to a specialist HPB centre) may in part be related to logistical barriers at certain institutions, and balanced against the pressures from other acute and elective procedures. Specialist HPB centres were associated with higher performance of emergency cholecystectomy. This may reflect a better understanding of the evidence comparing the outcomes of emergency and delayed cholecystectomy, or an enthusiasm to deliver an emergency cholecystectomy service.

There are limitations to this study. The data represent a 2-month snapshot of practice and may account for why hospital volume was not found to be important in this analysis, compared with other reports that have relied mainly on administrative data sets that may be incomplete or inaccurate^{2,30}. The extent of variation across hospitals in the present study was large, although the model accounted for only 65 per cent of the variation seen, suggesting the presence of other variables not characterized in this study. This may reflect factors that alter surgical decision-making which are difficult to quantify, such as complexity of other emergency admissions and pressures on emergency operating time. However, many surgeon characteristics, such as consultant subspecialty, would be expected to overlap with the hospital characteristics included here.

Initiatives targeting better delivery of all emergency surgical care, including a dedicated service for emergency surgery referrals, a surgeon-of-the-week practice model, operating room time during the day dedicated to emergency procedures, and 7-day working, have all been proposed as potential solutions^{36–39}. For example, dedicated emergency surgery team and operating lists are believed to provide efficient management of patients with gallstone disease^{40–42}. In the present study, however, performance of emergency cholecystectomy was not improved with emergency gallbladder operating lists, nor with increasing numbers of consultants who

performed cholecystectomy. This again suggests that there are hospital-level barriers in the delivery of effective emergency cholecystectomy services.

Similar variations in the performance of emergency cholecystectomy have been noted in other healthcare systems^{16–20}. Although the present study analysed data from patients treated in UK and Irish hospitals, patient and hospital characteristics are likely to be similar across other European and high-income countries. Here, 46 hospitals provided higher rates of emergency cholecystectomy than others. A qualitative service evaluation of these hospitals and selected centres that perform high rates of emergency cholecystectomy across high-income countries may provide a better understanding of the provision in these hospitals and provide a model for care.

Collaborators

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Supporting information

Additional supporting information may be found in the online version of this article:

Appendix S1 Variables included in multilevel random intercept logistic regression analysis of the association between patient and hospital characteristics and emergency cholecystectomy (Word document)