reviews

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Rationing—Talk and Action in Health Care

Ed Bill New

King's Fund and BMJ Books, £25, pp 261
ISBN 0 7279 1180 5

Rating: ★★

This is a book from a group with a mission. The members of the Rationing Agenda Group wish to promote "a continuing, broad and deep debate about rationing in the NHS." Their book shows, sometimes unintentionally, how difficult this may be to achieve.

The topic could not be more topical, and, by bringing together many of the "big names" in the rationing debate to explore key issues and dilemmas, the book provides a single volume that covers as much of the ground as most readers can possibly need. There is a range of standard articles on theory and on practice ("talk" and "action"), and Chris Heginbotham, in making the case that rationing is inevitable, reminds us of the scope and scale of the rationing that is taken for granted and not even featuring in current debates.

Some issues are debated from chosen opposing viewpoints, with each protagonist having the right of reply. Sometimes the results are impressive. Klein and New crisply dissect the problem, and indeed the wisdom, of attempting to define the package of health care that the NHS should provide. The clash of intellectual antlers as Williams and Grimley-Evans debate the rationing of health care on the basis of age was, for me, the highlight of the book.

The six accounts in the "action" section cover a broad range of initiatives, while demonstrating the gulf that currently exists between theorists and practice. It was only in this last section that the book felt slightly dated: an analysis of the potential role of the courts in rationing seems important in the light of recent events.

For all these reasons, the book should command a place on the shelves of healthcare libraries and the rationing cognoscenti. But it will not, I fear, succeed in its mission to stimulate widespread debate. It is often heavy going. Perhaps this is inevitable, as many of the concepts are complex and precision is correspondingly important, but it does not capture the casual reader with little time to spare.

The tone is faintly evangelical: the Rationing Agenda Group has seen the light and wants us all to do so too, while remaining completely undecided about what this would entail. Faced with tight budgets and soaring demand, we turn to the experts for help. Their answer seems to be that more discussion is needed, led perhaps by a Swedish style central committee of experts. This is the book's central weakness. Debate is valuable to busy people only if it helps them to solve practical problems. Perhaps the politicians have been right with their pragmatic approach.

Graham Winyard, *postgraduate dean, Wessex Deanery, Winchester*

American Surgery, An Illustrated History

Ira M Rutkow

Lippincott Williams and Wilkins, £52.93, pp 656
ISBN 0 316 76352 7

Rating: ★★★★

When you think about it, much of surgical teaching is based on history, particularly teaching done in the operating room. Surgical residents learn early in their training that it is not necessary to repeat mistakes made in the past, and that every useful operation has evolved through a process of trial and error. The concept of standing on the shoulders of giants is not lost on the present generation of surgeons. When asked to discuss a surgical procedure, most surgeons will begin by describing the origins of the operation and the surgeon associated with its development. Surgeons like history.

They will like this book. It begins with surgical practice in the colonial era, moves on to the introduction of anaesthesia, the treatment of injuries in the civil war, antisepsis and asepsis, both world wars, the age of specialisation, and ends with a discourse on recent controversies such as Medicare, surgical staffing studies, managed care, and declining remuneration. Along the way, there are excellent biographical accounts of major participants of each era. Probably the best and most detailed of these is that of William Stewart Halstead, who is represented honestly but with sensitivity and understanding. Halstead's ideas about surgical training and the development of what has become our surgical training system are well documented. Also of interest to me was the founding of the American College of Surgeons and its profound influence on hospital standards of care, credentialing, and records.

This chronological history fills the first 400 pages and is followed by a shorter section containing brief histories of surgical specialties, each including a short biographical description of 10 or 12 key pioneers and prominent surgeons. For reasons not explained, vascular surgery is not included. Also, the author has chosen not to include any living surgeons in this biographical material, so that several prominent cardiac and vascular surgeons such as Michael DeBakey, Denton Cooley, and C Walton Lillehei are only briefly mentioned.

Some of the strongest messages of this book come from the numerous illustrations, which in some way reveal more about the past than does the text. These lithographs, paintings, illustrations, and photographs are each described in detail and, even if presented alone, would be an adequate history. For example, the section on the civil war begins with a photograph of a stack of a dozen amputated legs, poignantly symbolic of that tragic episode. The illustrations are the most moving part of the book.

This is an outstanding book and will be the standard by which future historical collections of American surgery will be measured.

William Stoney, *professor of cardiothoracic surgery, Vanderbilt Medical Center, Nashville TN, USA*

Reviews are rated on a 4 star scale (4=excellent)

Health, Civilization and the State: A History of Public Health From Ancient to Modern Times

Dorothy Porter

Routledge, £16.99, pp 376
ISBN 0 415 20036 9

Rating: ★★★

How boring is the history of public health? As Dorothy Porter notes in her introduction, the subject tends to provoke a big yawn, both from students, who are bored by accounts of bureaucratic and technological reforms, and from historians, who are bored by the usual grand narrative of progress. Because historians don't write these histories any longer, George Rosen's *A History of Public Health*, originally published in 1958, is still widely used and recently reappeared in an updated and expanded version.

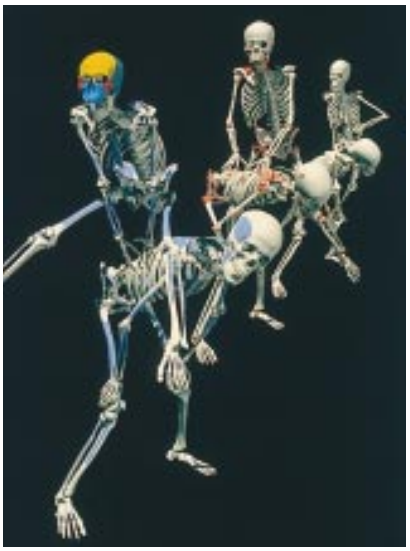
But here we are, faced with a new history of public health "from ancient to modern times" written by a modern historian. Porter acknowledges the "contemporary intellectual climate of postmodernist relativism" and apologises for her grand narrative of only the Western tradition in public health but then makes a serious attempt at telling "the history of collective action in relation to the health of populations." Her history is not only remarkably contemporary but also very international. Its emphasis is on tracing the origins of our current thinking about the role of the state, and it is precisely in this area that the idea of a linear progression towards ever more effective public health action is indeed untenable.

This is clearly illustrated by the recent history of state intervention in the provision of welfare, and is one of the main themes of the book. In most industrial societies state intervention started in the early years of the century and increased until the mid-1970s. A detailed account of the history of welfare provision in Germany, France, Britain, and Sweden shows that, under the surface of widely different political events and ideological discourses, all European countries were moved by the same collectivist tendencies. European states instituted comprehensive welfare systems in the belief that universal welfare provision would turn public protection into citizenship for everyone. After the second world war, the expansion of the welfare state was facilitated by economic growth and by the then widespread belief that welfare provision would stimulate economic growth by making the labour force healthier, better educated, and more mobile.

This progression was interrupted around 1980, as some of the criticisms of the welfare state which had prevented the United States from adopting comprehensive welfare systems became increasingly popular around the world. The economic crisis necessitated cuts in public spending, and the example of Japan suggested that competitive economies wereincompatiblewithlargepublicsectors.Universalism was accused of failing to discriminate in favour of those in greatest need and of creating a culture of dependency. Radical reforms were advocated, but, although some important changes occurred everywhere, there was usually a large gap between political rhetoric and practical policies because of the popularity of the welfare state among the middle classes. The largely unsuccessful attacks by the Thatcher government on the NHS serve as a striking illustration.

This book is far from easy reading, burdened as it is with abstractions and references, with details of political events, and names of protagonists. It does not replace George Rosen's old fashioned history of technological advances because one will look in vain for a disease-specific account of the achievements of public health. It will even be boring for students, but it is an absolutely fascinating book. The issues raised are timely and unsettling, largely unaddressed as they are by contemporary public health professionals. The rise of the public health profession is closely linked to the process of increased state intervention in all spheres of life, and the implications of the recent changes in dominant ideology for the practice of public health have yet to be thoroughly analysed.

Johan P Mackenbach, *professor, Department of Public Health, Erasmus University Rotterdam, Netherlands*



THE WELLCOME TRUST

The Interactive Skeleton. A 3D screen image on display at The New Anatomists exhibition at the Wellcome Trust's Two10 Gallery, 210 Euston Road, London NW1 2BE which runs until 16 July

BOOKCASE

● Perhaps reports of the death of the textbook have been exaggerated. H G Beger and colleagues' **The Pancreas: A Clinical Textbook** (Blackwell Science, £295, ISBN 086542 420 9) is a huge new one. It costs nearly 300 pounds and probably weighs about the same. A total of 222 contributors, all unreconstructed narrative reviewers, have written 160 chapters. Unfortunately, the publishers have no plans to bring out a CD Rom version.

● Anyone starting laboratory research would find Kathy Barker's **At The Bench: A Laboratory Navigator** (Cold Spring Harbor Laboratory Press, $45, ISBN 0 87969 523 4) invaluable. It's a ring bound manual that explains everything from how to use a centrifuge to how to give a research seminar.

● **Smoking—The Inside Story** (Woodside Communications, £7.99, ISBN 0 9533945 0 6) is an account of the physiological and pathological effects of cigarette smoking written in non-technical language. Alex Milne and James Northfield are motivated by the best intentions, but surely everyone already knows that smoking is bad for your health. Will giving people the information in more detail be more persuasive?

● If you find that the neuroanatomy you learnt at medical school stands you in poor stead when confronted with the results of modern neuroimaging, refresh your memory with J Hanaway and colleagues' **The Brain Atlas—A Visual Guide to the Human Central Nervous System** (Oxford Science Publications, £24.95, ISBN 1 891786 05 9). Particularly helpful is the display of magnetic resonance images and photographs of sections of fixed brain on facing pages.

● Few would argue against the proposition that science is the most influential knowledge system in modern society. But it is far from obvious exactly what science is. The work done by a palaeontologist, for example, is not strikingly similar to that of a particle physicist, although both would certainly claim to be scientists. **Science in the Twentieth Century** (Harwood Academic Publishers, £80, ISBN 90 5702 172 2) is a large multi-authored volume edited by John Krige and Dominique Pestre that explores some aspects of this problem. Doctors no doubt will be interested in Christopher Lawrence's chapter on clinical research. But perhaps the main reason to dip into the book is to enlarge one's understanding of the nature of the complicated enterprise that we call science.

Christopher Martyn, *BMJ*

A prayer from the dying

June Burns, a 59 year old woman with terminal bladder cancer, wants to die before her pain becomes unbearable. In an attempt to persuade others of her right to die as she chooses, she has appeared on Australian television in an advertisement sponsored by the Voluntary Euthanasia Society of New South Wales.

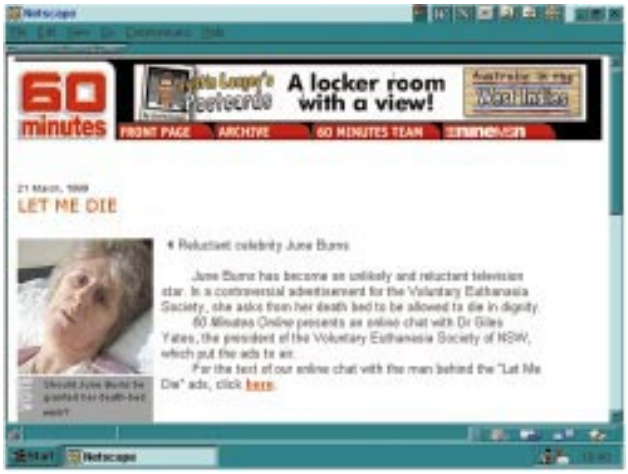
The advertisement features Mrs Burns speaking from her hospital bed, appealing for legal sanction to kill herself. "If I was a dog, by now the RSPCA would be on to my husband for cruelty and would have me put down straight away," she says. "I feel life is very precious and I've enjoyed every moment of it and I wish I could go on, but I can't and I'd like to die with dignity."

The advertisement has had a major impact both on the public and on Mrs Burns. Carmel Marjenberg, coordinator of the Voluntary Euthanasia Society of New South Wales, explained that the advertisement was intended to influence public opinion to support legislation allowing voluntary euthanasia. She said the society was "overwhelmed" by the response to the advertisement, which had generated more positive reaction from the public than any other activity they have organised.

However, some media reports have questioned whether the advertisement has had negative consequences for Mrs Burns. On 16 March, just before the advertisement was screened, the *Australian* newspaper ran a story under the headline, "Euthanasia ad takes toll on dying woman." The story claimed that Mrs Burns had been "so traumatised" by the experience that "she may have to withdraw from the landmark advertising campaign." Spokespeople for the advertising agency and for the euthanasia society denied this account. Ms Marjenberg reported: "June hadn't anticipated the interest the advertisement would create … She's not well, and something like this takes a hell of a lot out of you. But she's a fighter. She's recovered now, and she wants to do as much as she can." Nevertheless, a decision has not yet been made on whether she will continue in what was originally intended to be a series of advertisements.

The advertisement is the latest in a series of events over the past few years that have galvanised Australians' interest in voluntary euthanasia. Advocates claim that recent surveys show that 70-80% of the population support the practice. The world's first voluntary euthanasia law was passed in 1996 by the local legislature in the Northern Territory. Four terminally ill people died by suicide under the terms of the law—using a remote controlled intravenous infusion device supervised by a doctor—before it was overruled by the national government eight months later.

The national government still does not support euthanasia nor, formally, do any of the states. But they are not keen to apply legal sanctions. In Victoria seven doctors publicly acknowledged their participation in voluntary euthanasia without attracting intervention by the state authorities. The subject continues to attract considerable public attention and parliamentary discussion.



Mrs Burns' story on the *Sixty Minutes* website (sixtyminutes.ninemsn.com.au/news/22987.asp)

Groups opposed to euthanasia tried to ban the advertisement, but it was cleared for transmission by the Federation of Australian Commercial Television Stations. The federation decided that the advertisement was political in nature and allowed it to be screened, subject to the regulations required of all political advertising.

After the commercial was first shown on Channel 9 television in New South Wales, it was the subject of an extended story on the channel's current affairs programme *Sixty Minutes*. In an interview, Mrs Burns strongly denied suggestions made by some media commentators that she was coerced into making the commercial or that she was depressed. In particular, she was keen to emphasise that her views were not a consequence of receiving inadequate palliative care. After the interview, comments from members of the public in an online discussion on the programme's website were almost universally positive. Subsequently, another television station, at yet unnamed, has agreed to broadcast the advertisement free of charge as a "community service."

Mrs Burns became aware of the euthanasia issue at the time of her father's death, also from bladder cancer, 25 years ago. She joined the Voluntary Euthanasia Society of New South Wales 10 years ago. The society established a relation with the advertising agency Ammirati Puris Lintas that enabled it to produce the commercial at a reduced cost. When Mrs Burns was approached to participate she readily agreed.

Jeremy Anderson, *psychiatrist, Australia*

WEBSITE OF THE WEEK

www.Bristol-Inquiry.org.uk The Bristol inquiry resumes after its Easter recess and will continue to post its verbatim transcript on the web. This is a lot of information—too much—but it does provide detail and colour. It records, for example, an interruption by one Mrs Bye, who, on the first day, laid "a token" (the transcript does not say what) on the table and expressed the wish that it would remain there throughout the course of the inquiry as a sign of "the most wonderful gift in life, the life of a child."

Some concession is made to the needs of those who are pressed for time: each day's transcript has a short summary at its head, but after that you're on your own with a chunk of text about half the length of a novel. According to the inquiry's principal counsel, Brian Langstaffe, the legal team has read more than half a million pages of written evidence since October. Every document has been scanned for relevance, boiled down to a "core bundle" of some 15 000 documents, "redacted" to ensure patient confidentiality, and made available on searchable CD Rom and, as hypertext links, from the transcript on the web. It's quite a shock to be confronted by an electronic scan of an A4 sheet of paper on which the only easily legible words are "Continuation sheet." Marshall McLuhan considered that "the medium is the message": if so, doctors, whose bad handwriting has long been a subject for humour, are conveyed in this medium as crude primitives.

Not only are the transcripts being put on the web, but the proceedings are being broadcast "under controlled conditions" in health centres in Barnstaple, Truro, and Cardiff. This is certainly a display of multimedia technical virtuosity. Let's hope that we are all satisfied with the outcome: an inquiry into the inquiry could get very time consuming indeed.

Douglas Carnall
BMJ

PERSONAL VIEW

Will clinical governance make a difference?

Another meeting on clinical governance and yet again it is surgeons who are cast as the main villains by purchasers, managers, and even fellow clinicians. Since surgery is the only discipline where it is easy to measure outcome all discussion on this topic seems to revert to surgery. I ought to be used to the charge of being an élitist megalomaniac. After all I am a neurosurgeon, and everyone knows that the only difference between God and a neurosurgeon is that God does not want to be a neurosurgeon. However, I do not think that I fit this caricature. What is it that really motivates me and my colleagues?

For me, surgery has always been a vocation. I have been able to accept the responsibility of operating only by setting myself the highest standards. Of course, resources are limited, but I used to be proud to be part of a system that allowed for ideals other than personal financial gain. To be a successful surgeon you have to learn to cope when things go wrong. It is not my successes that I remember, it is my failures, which provide the motivation to get it right next time. The system may have been imperfect but I felt supported by the naive view that when things did go wrong I would be protected by a collective responsibility. The key was simply to do my personal best.

It would have been nice to audit my practice in detail so as to define best practice, especially as my workload was steadily increasing with each successive efficiency target. However, attempts to do so using the hospital information systems were doomed to failure; these had been set up to service the requirements for purchasing, not to provide clinically relevant information. So I resorted to data collection by reviewing notes on selected topics—audit of a sort, but by no means comprehensive. Operating on more patients meant an increase in the absolute number of complications even if there was no increase in complication rate.

But the main psychological blow of the past few years came with the patient's charter. The majority of patients, as well as clinicians had regarded NHS health care as a privilege. By and large they accepted the limitations of the service as long as their carers actually cared. Overnight health care became a right. With rights come expectations and intolerance.

Then came the Wisheart affair at Bristol. Surgeons were now wholly and personally responsible for outcome in their patients, irrespective of everything else including the limitations of the service, political pressures, underfunding, even the ruling of the General Medical Council. I immediately referred to the professional guidelines regarding safe neurosurgical practice, finding that my workload was twice that recommended. I therefore set about halving my workload, an initiative supported by the trust but only on a temporary basis.

From that moment things have improved. I seem to have time for patients again and I have time to organise my own audit. I know what my mortality rate is, but more importantly I know why the patients died and whether their deaths reflected inadequacies in their care or the severity of their presenting condition. I can therefore respond to the simplistic notion that excellence in surgery is inversely proportional to mortality rate. I can now tell patients exactly what my complication rates are for a procedure. In time I will accrue outcome data as well. In short, my practice is under control again. The question is, will it last?

> Excellence in surgery is inversely proportional to mortality rate

The UK government's document, *A First Class Service*, defines clinical governance as a "framework through which NHS organisations are accountable for the quality of clinical care." There is, after all, to be a corporate responsibility for health care involving clinicians, managers, purchasers and politicians. In theory, therefore, the trust will now have no alternative but to find the resources for safe practice. The responsibility of the purchasers and their political masters will be either to provide those resources or to prioritise access to care. They will have to take responsibility for rationing, which so far they have studiously avoided doing.

My wife is encouraged by recent events. Statutory requirements regarding the working week will make the 80 plus hours a week I have been working illegal. If I can halve my workload on a permanent basis she hopes that I will be less depressed, regain my enthusiasm for the job, and have more time for the children. I too hope that once again it will become my privilege to care for people. With a sustainable reduced workload I will be in a position to embrace the principles of clinical governance wholeheartedly. Forgive my scepticism, but I remain to be convinced that trusts, purchasers, and politicians will do the same. The stereotype of the ogre surgeon provides too convenient a scapegoat.

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

David R Sandeman, *consultant neurosurgeon, Bristol*

SOUNDINGS

All change

I think that I am beginning to lose count. The first was a very long time ago, and I was caught up in it only because, for reasons that seemed good enough at the time, I had taken a year out after the then traditional first year. When I came back they had changed the curriculum.

So the year I joined was the first to test the new arrangements. The anatomists—having endured a cut in the teaching time from 900 to 500 hours—responded robustly, teaching the same old stuff almost twice as fast.

We rose to that challenge, and to similar demands from physiologists and biochemists. The year behind us did less well; what to us was a challenge was to them merely absurd. The course was judged a success, but a few years later the curriculum changed again.

Again our lot was caught. Some resented the loss of an anticipated long summer vacation. I did not mind. Weeks and weeks of general medicine in Kirkcaldy seemed much more fun.

Then things changed again: something to do with integrating clinical and non-clinical subjects. Products of the old system, we had failed to notice the disintegrated nature of our education until it was thus pointed out to us. Happily, most of us seem to have coped anyway. Now our most recent curriculum is in its turn considered obsolete. Too integrated? Or not integrated enough? No matter. It's going shortly, in favour of something completely different.

A very long time ago an Edinburgh medical student was reproached by the professor of anatomy, one Munro Tertius, the disappointing third generation holder of an apparently hereditary post, for not taking notes in class. The student replied, quite reasonably, that there was no need: his father had left him some perfectly adequate notes from lectures given by the speaker's grandfather. Curricular stability, it seems, was once valued very highly, at least in Edinburgh.

But the worry now is that—with everything else about medicine changing so fast—what we teach is changing far too slowly. Hospitals shrink. Surgery fades. New technologies breed faster and faster. Medicine deinstitutionalises itself. Distance learning burgeons. So how do yesterday's doctors prepare tomorrow's for all that?

The curriculum is long, the art now almost too brief to be captured by it. Time not for a new curriculum, but for a permanent curricular revolution. Any volunteers?

Colin Douglas, *doctor and writer, Edinburgh*