

reviews

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Doctors Talking

Ed Hellen Matthews, John Bain



Scottish Cultural Press, £7.95,
pp 126
ISBN 1 84017 030 1

Rating: ★★★

Resistance to the health reforms of the 1990s has taken many forms, but among general practitioners a recurrent theme has been the threat to personal care and the doctor-patient relationship. Matthews and Bain have set out to show us what it means to be a family doctor in Scotland, in the words of 11 general practitioners practising in a variety of settings. These chatty interview accounts of general practice in deprived inner cities, suburbs, rural villages, and remote Scottish islands and highlands vividly illustrate the meaning of personal care.

In the inner city a 9 year old boy is brought in by his grandmother for a psychiatric referral. She is worried that he will not survive secondary school because he prefers reading indoors to setting cars on fire. Counselling services in the same practice reveal unresolved grief over socially unacceptable deaths such as young men killed while driving stolen vehicles. Island doctors arranging for their patients to get to the mainland hospital by ferry have to cope with cuts in the ferry services. Patients in rural areas make their requests to accommodate their doctor's schedule, including a man prepared to wait until the next day after a heart attack.

A recurrent theme is the importance of personal relationships and the general practitioner's role in the community. All the contributors, who are not named, are clearly committed to their patients and to their communities. Terminal care is identified as a particularly rewarding part of general practice. Several comment on the disappearance of the traditional Scottish granny, and how this has increased patients' dependence on the health service. The fluid boundaries of general practice are a double edged

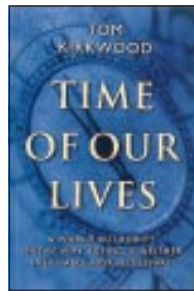
sword: general practitioners participate in people's lives but increase their workload in doing so. Rationing is an issue: the doctors would rather be their patients' advocate than the rationer, and health in deprived areas might benefit more from spending on jobs and housing rather than health care. Several contributors pay tribute to their practice teams.

General practitioner educators still use Berger and Mohr's book *A Fortunate Man* (published in 1967) as a way of introducing newcomers to a traditional model of general practice, in which the doctor's role as a member of the community is celebrated. *Doctors Talking* is a contemporary vehicle for the same kind of message. I think it could be usefully read by medical students, preregistration house officers, and anyone else who wants to know general practice at its best. Its inspiring message may counterbalance the negative images that seem to be deterring young doctors from choosing general practice.

Nicky Britten, senior lecturer in medical sociology, Department of General Practice and Primary Care, GKT School of Medicine, King's College, London

Time of Our Lives

Tom Kirkwood



Weidenfeld and Nicolson,
£20, pp 287
ISBN 0 297 84247 1

Rating: ★★

No matter how much our lives have improved over the past century, the never ending search for health and longevity continues. Unfortunately, it seems that we humans want it all—not only do we relish the prospect of long life, but we want to enjoy it with the undiminished mental and physical prowess of youth. Modern science tempts us to believe that anything is

possible when it comes to improving the human machine, but how practical is it to seek immortality?

In *Time of Our Lives* we are offered a realistic, albeit somewhat less than satisfying, explanation of the science of ageing. Thomas Kirkwood, in an extension of his many journal publications on the topic, provides an easily readable and informative look at ageing, unfolding its mysteries in a warm and often humorous style. Many myths and theories of ageing are challenged, as Kirkwood lays a substantial foundation to support his "disposable soma" theory. Fortunately, a simple short course in genetics is provided, which is necessary for most readers, as understanding this theory of ageing relies on knowing some basic genetic concepts.

A feeling of promise builds up as we learn more about gene therapy, hormones, and the sex differences of ageing. Kirkwood, as though writing a rich novel, develops the various characters in this story. In essence, he leads us through the drama of cellular birth, life, and death, emphasising the roles of DNA, free radicals, mitochondrial mutation, and a large cast of microscopic soldiers

doing battle in each cell of our bodies. Supported by his statement that "there is probably no single mechanism of ageing," we are left with the thought that there is little we can do, as large, clumsy mammals, to help the good armies keep our cells healthy. Immediately after the chapter on cells comes one that considers the larger universe of our organs and other physiological systems, describing the course of their ultimate failure. After only a few pages, readers might easily ask, "But what can I do to age well?"

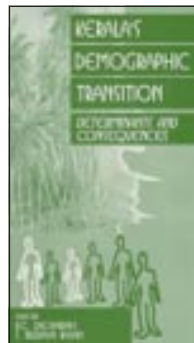
The answer to this question is, perhaps, the disappointing aspect of this book, as we are reminded, yet again, to watch our diets, exercise regularly, possibly consider some vitamin and mineral supplements, and keep our minds active. Most readers will, I suspect, want something more. None the less, Kirkwood assures us that we are making progress in understanding the mechanisms of ageing, but it will be future generations who are the beneficiaries of this knowledge.

Susan Charlifue, research supervisor, Craig Hospital, Englewood CO, USA

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

Kerala's Demographic Transition: Determinants and Consequences

Eds K C Zachariah, S Irudaya Rajan



Sage Publications, £29.99,
pp 367
ISBN 0 8039 9392 7

Rating: ★★★

The achievement of demographic transition—with fertility at replacement level—by the south Indian state of Kerala, despite it being one of the poorest states in the country, has overturned the previous assumption that demographic transition could occur only in wealthy communities. This book covers the subject of Kerala's success in four sections: demographic transition, determinants of demographic change, consequences of demographic change, and migration.

Two questions arise from Kerala's experience: first, can the state's policies be applied to other parts of India, and, second, can they be transplanted to other low income communities, notably in sub-Saharan Africa? The first question is answered in the affirmative, although the discussion is not as full as I would have liked, and the second question is not addressed at all.

It is necessary to examine the factors that enabled Kerala to achieve its demographic targets. Until the development of road and rail links, Kerala was cut off from the rest of south India by the mountains of the Western Ghats and was influenced by its trade with Arabia, China, and, later, with Europe. Christianity was established long before the Portuguese arrived in the 16th century, and today Kerala has the largest proportion of Christians (20%) of any Indian state (2% in India as a whole). The Christian community, helped by missionaries, set up schools and hospitals and was supported by

A book that changed me

Has a book ever made you rethink your life? If so, let *BMJ* readers know. The book that you choose does not have to be medical. Send your contributions of up to 400 words to Kamran Abbasi by post or email (kabbasi@bmj.com)

progressive rulers of Travancore and Cochin, which were amalgamated in 1956 to form the state of Kerala. From 1956 onwards there has been continuous expansion and development of the education and health services.

The social structure of Kerala was uniquely favourable to the emancipation of women, influenced by the tradition of matrilineal inheritance practised by the powerful caste of Nayars. The combination of free primary and secondary education, introduced in the early part of the 20th century, with female emancipation, laid the foundations for high female literacy (75% in Kerala, 30% in India as a whole), which in turn determined the acceptance of free family planning services. But the precondition for this was low infant mortality, which, by 1993, had fallen to 17 deaths per 1000 live births (compared with 90/1000 in India). Thus, the order of events essential to achieving demographic transition was high female literacy, low infant mortality, low birth and fertility rates, and easily accessible free family planning services.

Clearly, for historical reasons Kerala's experience cannot easily be replicated in other parts of India. One of the most telling tables (p 74) shows a time lag of about 20 years between the achievement of specific levels of fertility and infant mortality by India compared with Kerala. However, in the neighbouring state of Tamil Nadu fertility has almost reached replacement level in spite of a high level of female illiteracy. This has been achieved by a family planning programme integrated with maternal and child health services. What both states share is the political will to succeed, which does not seem to be present in some other Indian states.

In spite of the depressing state of sub-Saharan Africa, Kerala's policies hold some lessons for the region. Currently, most of these states cannot afford a level of education and health services that would ensure demographic transition. African societies are pronatalist with a strong patriarchal tradition, and it is the husband who normally determines the desired number of children (although in one survey in Nigeria nearly a fifth of men and women replied that "god made the decision"). Until recently, family planning programmes have concentrated on women, and the failure to involve men is now seen as a mistake. Similarly, attempts to promote family planning in the face of high infant mortality are unlikely to succeed. Clearly, the key to improvement in sub-Saharan Africa lies in the reduction or, better, the cancellation of external debt repayment; this would enable adequate education and health services to be developed.

John A Black, retired consultant paediatrician, Victoria Mill House, Framlingham, Woodbridge

BOOKCASE

● The man or woman on the Clapham omnibus feels instinctively that screening must be a good thing. Many clinicians think the same—especially when it concerns diseases that they happen to have a special interest in. Read **Screening** (C Reckham, *British Medical Bulletin*, £34.95, ISBN 1 85315 345 1) for the intellectual equivalent of a cold shower. Did you know, for example, that, over a lifetime, a woman is more likely to receive a cervical smear result that incorrectly identifies her as having a condition that might develop into cervical cancer than she is of actually getting cervical cancer?

● It's always a pleasure to come across a textbook written by someone who can communicate their enthusiasm for their subject. The clear diagrams and racy style of **Lecture Notes on Urology** (J Blandy, Blackwell Science, £22.95, ISBN 0 632 04202 8) will appeal to both medical students and neophyte surgeons.

● **A Simple Guide to Blood Gas Analysis** (P Driscoll, T Brown, C Gwinnutt, and T Wardle, BMJ Books, £19.95, ISBN 0 7279 1107 4) is another book that students will like. The physiological principles are illustrated by a combination of clinical case histories and cartoons. Boxes summarise the more important points, and each chapter ends with a quiz so that readers can check whether they have taken everything on board.

● If I hadn't just had my right carpal tunnel decompressed, I might have thought Jacob Bronowski's description of the hand as "the cutting edge of the mind" a smidgen over the top. But at the moment, as I struggle even to hold a pen, it seems dead right. **The Psychobiology of the Hand** (K J Connolly, ed, Cambridge University Press, £45, ISBN 1 898 68314 X) deals with the anatomy, physiology, and neurology that underlie manual skills. I was especially fascinated by the phylogeny and plasticity of cortical motor control. In the pig almost the whole of the precentral gyrus, the primary motor area, is taken up by the snout. And functional magnetic resonance imaging has shown increased cortical representation of the fingers of the left hand in players of stringed musical instruments.

● A substantial proportion—perhaps as high as 30%—of sheep ticks contain *Borrelia burgdorferi*, the spirochaete that causes Lyme disease. Despite their name, sheep ticks live on deer and many other wild and domestic animals. If you look after patients who prefer the countryside to theme parks for their recreation, suggest that they read **Ticks. A Lay Guide to a Human Hazard** (G Hendry and D Ho-Yen, Mercat Press, £4.99, ISBN 1873644 809). It explains how to avoid tick bites and what to do if you are bitten.

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Popularising hospital performance data

The publication last week of the first set of performance tables for hospitals in England provoked a storm of comparisons between hospitals by the media. England's Department of Health is keen, however, to stress that comparative death rate data should not be used to "name and shame" particular hospitals. Within two hours of the department's press conference last Wednesday, BBC television reported live from a ward at St George's Hospital, London, pointing out that it seemed to have the worst death rate after non-emergency surgery of any teaching hospital in the country. By 6 pm, the BBC's online news service had pinpointed St George's Hospital, Salford Royal Hospitals NHS Trust, and North Devon NHS Healthcare Trust—all apparently having high death rates compared with their counterparts.

Thursday's national newspapers continued the exercise. The *Times*, *Independent*, *Daily Telegraph*, and *Guardian* published excerpts from tables listing different hospitals' performance, and interviewed representatives of those hospitals that seemed to have the worst performance. Among the tabloid newspapers, the *Daily Mail* dedicated two pages to "disturbing differences in standards of care,"

while the *Sun* and *Mirror* dealt with the story in a single column.

The hospitals concerned have been quick to point out that there are many factors contributing to death rates and that the way the figures are collected may make things look worse than they actually are. For example, St George's said it frequently treated very sick patients transferred from other hospitals, while Salford said the death of the only patient treated in a particular age group had skewed its data.

Commentators have suggested that a lack of general understanding of statistical conventions—such as confidence intervals—leads to misleading coverage of these sorts of data. John Appleby, director of the health systems programme at the King's Fund, pointed out: "When it comes to confidence intervals people have an almost emotional difficulty in getting their head round them." He explained that people find it difficult to accept that a figure is not a definite one but could fall within a range. He also pointed out that confidence intervals between health authorities at the top and bottom of some of the performance tables nearly overlapped, so publishing a table ranking their performance may be meaningless.

Professor Harvey Goldstein, a researcher who has studied educational league tables in Britain and surgeons' league tables in the United States, added that it is very difficult to compare like with like by adjusting for factors such as deprivation. Even when this is done, sampling errors can still be huge—particularly if small numbers of patients are involved. He warned that the poor data used in the latest tables mean that the government is displaying false openness:

DEATH RISK AT TOP HOSPITALS

THE risk of dying after surgery or a heart attack varies dramatically depending on which hospital treats you, a government report said yesterday.

And death rates are highest at some of Britain's top medical centres including Royal Brompton and Harefield heart hospitals and the Royal Mars-

DAILY MIRROR 17 JUNE

"The government could be accused of deliberately withholding information about the quality of its statistics. The apparent publication of information which looks as though it is giving you something you don't have is in some ways worse than not publishing, because it's misleading."

Meanwhile, some doctors fear that inappropriate media coverage will lead consultants to change their behaviour, excluding patients who will have an adverse effect on their hospital's performance statistics. Jim Johnson, chair of the BMA's Joint Consultants Committee, said: "It is possible that this type of exercise might lead to surgeons being a bit more choosy about who they operate on. If I found myself in a league table and my hospital was down at the bottom, I would be a little bit choosier next year. I wouldn't announce it, but it would be in the back of your mind."

Overall, however, Mr Appleby believed that the "naming and shaming" exercise was a healthy one: "You don't have to call it shopping around, but being more of an informed consumer. If the parents involved in the inquiry into their babies' deaths at Bristol Infirmary had had access to clear and understandable data about clinicians' performance, perhaps they would not have consented to the treatment." And the previous experience of the health service in Scotland, five years ahead of the rest of the United Kingdom in publishing such data, seems to be reassuring. A spokesman for the Scottish Office said that when comparative clinical outcome data first appeared in 1993 they were the subject of a media scare: "The media chose to put the 'death league' tag on them at first, but now interest has lessened." He explained that the information is used by doctors and managers in the health service but is not particularly "punter friendly" because of its complex nature.

As time goes on, the English tables could go the way of their Scottish counterpart, becoming a matter of routine and perhaps even indifference to the public. But, in spite of the data's inadequacy, national and local coverage about hospitals' performance should, in the long run, have a positive effect on quality of care. Mr Johnson concluded: "The bottom line is someone's always going to have to be 400th, and it's really about getting the difference between number one and number 400 to be smaller. The secretary of state is well aware that it's about narrowing that margin rather than about witch hunts."

Pat Anderson, freelance medical journalist



WEBSITE OF THE WEEK

www.doh.gov.uk/indicat/indicat.htm This week the government launched its scheme to publish "on the issue that really matters to the public"—quality and performance in the NHS. Naturally, part of its strategy is to release the information on the web, although you have to work quite hard to get to grips with it.

The main feature of the site was some fairly hefty PDF (portable document format) files, which I was going to criticise for wasting bandwidth and being hard to navigate round. Over the weekend, however, work has continued, and data for each health authority's performance have been posted to the site as Microsoft Excel spreadsheet documents. So I'll complain about that as well: publishing information in proprietary format forces users to pay tax to Bill Gates as well as to the government.

Users with low bandwidth connections will have to be fairly certain that they know what they want before they hit the links. Unfortunately, their naming is not intuitive. Clicking on "Clinical Indicators" (www.doh.gov.uk/indicat/nhsci.htm) leads to a 775 kb PDF file, which users with a 56 k modem on a dial up connection might reasonably expect to download in 3 minutes under optimal conditions. In fact, it does not contain any data, which are stored in a 3793 kb Technical Annex of 292 pages from www.doh.gov.uk/indicat/techannx.htm.

When you have obtained the information, each performance indicator—such as the number of deaths within 30 days of elective surgery by hospital trust—is fully discussed, and the data are presented as absolute numbers as well as percentages with confidence intervals. I could not find ranked comparative data by named trust within the time and resources of writing this column, but the government has done just enough to get the raw data into the public domain, and has left plenty of scope for enterprising individuals—the media—to repackage the data in more usable form.

Douglas Carnall
BMJ

PERSONAL VIEW

Abandoning diastole

Whenever possible medical practice should be evidence based. Hypertension is one of the world's most common causes of premature morbidity and mortality, and national and international bodies have published guidelines on hypertension management.

Recent guidelines have proposed that decisions on management of hypertension should take into account estimates of absolute cardiovascular risk based on an assessment of concomitant risk factors, including lipid profile, smoking habits, and the presence or absence of diabetes. While this has certain merits on scientific grounds, recommendations based on assessment of five year absolute risk ignore longer term benefits of intervention (life years saved) for younger patients who would be denied treatment if shorter term estimates of risk were used.

This confusion among doctors and uncertainties about treatment strategies must be a major explanation underlying the appalling levels of blood pressure control in the United Kingdom and other European countries. The recent *Health Survey for England*, using the most conservative definitions of control of blood pressure (<160 mm Hg systolic and <95 mm Hg diastolic), reports that around 70% of people with known hypertension are uncontrolled and subject to high residual cardiovascular risk.

Those responsible for previous guidelines have consistently failed to communicate or facilitate the uptake of the key messages by those who practise medicine. New guidelines in preparation, no doubt more sophisticated and comprehensive, will not address this issue. Since the old guidelines seem to have had little impact on practice, why should the new ones?

The key issue in hypertension management in primary care is the treatment of those patients who will benefit from treatment and to ensure that treatment failures are addressed by modifying drug treatment to achieve control of blood pressure.

- Rule 1: Abandon routine diastolic blood pressure measurement. Systolic pressure is, in general, a better predictor of future cardiovascular events than diastolic pressure, which is less accurately assessed. When systolic pressure is raised, the level of diastolic pressure is usually irrelevant for the purpose of therapeutic decision making. The exception is in the case of severe hypertension where high systolic combined with high diastolic pressure—for example, > 125 mm Hg—may indicate malignant

hypertension, which constitutes a medical emergency.

- Rule 2: Apply the “150” systolic blood pressure rule. The “150” systolic rule is a simple, pragmatic, and more readily applicable rule than the alternative and often difficult interpretation of the various guidelines on thresholds to treat. Applied simply the threshold of 150 mm Hg systolic pressure is used as a guide for intervention following repeated measures of blood pressure over a period of weeks or months depending on the severity of the elevation.

For low risk, uncomplicated patients a more conservative approach may be adopted by raising the threshold to 160 mm Hg. A similar threshold is widely advocated in the elderly (> 60 years). In high risk patients, particularly those with diabetes, the threshold may be lowered to 140 mm Hg, in line with the recommendations of certain bodies—for example, in the sixth report of the Joint National Committee (JNC-VI) of the National High Blood Pressure Education Program.

These recommendations are broadly compatible with calculations of risk based on epidemiological data and intervention trial data if “in-trial” blood pressures are used as the basis for extrapolation.

- Rule 3: Assess cardiovascular risk by examination and investigation. Cardiovascular risk assessment in people with hypertension should be based on careful examination for evidence of target organ damage (retinal vessels, cardiac enlargement or failure, or both, cerebral, or peripheral vascular pathology) and simple investigations for concomitant risk (diabetes, lipid profile) and target organ damage (electrocardiography, renal function).

- Rule 4: Modify therapy if initial drug is ineffective, partially effective, or poorly tolerated. Where treatment fails and blood pressure does not fall below the treatment threshold, drug dosage should be increased (except diuretics), treatment changed, or combinations of drugs introduced to achieve goal pressures.

Those who will no doubt challenge these proposals on the grounds of oversimplification should note that were physicians to achieve a goal systolic pressure of <150 mm Hg in the majority of their patients this would result in a reduction in their risk of a future cardiovascular event of around 25% compared with current practice and a substantial saving of deaths from heart attacks and strokes.

Peter Sever, professor of clinical pharmacology and therapeutics, London, and past president of the British Hypertension Society

Around 70% of people with known hypertension are uncontrolled

SOUNDINGS

Bed blocking for beginners

For many years now our students have returned to base from their scattered clinical attachments with a case presentation for their final session.

We are not looking for traditional grand rounds material—in which the obscurity of the diagnosis is matched only by the modest diagnostic sagacity of the team involved—but for the really difficult stuff: the kind of case where people had to stop, reflect, worry, or even argue not about biomedical issues, great or small, but about social or ethical aspects of care.

Usually it works and the session comes alive, combining hints of end of term jollity with frank, sometimes clumsy debate. In just over a couple of hours, chaperoned by a wise and gentle colleague who knows a lot more about medical ethics than the rest of us, we tour the wilder shores of the care of elderly people in a series of cases selected, presented, and discussed by students.

Some themes become familiar. Where do you draw the line between finding out what's going on and providing terminal care by investigation? What if the patient cannot be consulted and the family disagree? What happens when a valiantly unrealistic eccentric insists on discharge and no one else thinks that it's a good idea?

Autonomy, beneficence, non-maleficence, and justice come and go in argument, nudged in if necessary by one of the grown ups. If students, so often in search of certainty as a measure of early professionalism, come away with the impression that quite often there are no best answers then the time is well spent.

Recently—say over the past five years—there has been a change in case mix. Quite often these days we find ourselves discussing not what is best for the patient but how he or she might be got rid of—not in any illegal way, you understand, but really, this old lady is taking up an acute bed and she doesn't really need to be there and a lot of other people could be using it if she could go somewhere else but for various reasons there really isn't anywhere for her to go.

Of course, it's difficult, particularly for the old lady and her family, but we go through it all: changes in policy, pressures on acute services, loss of long term beds, gaps in community provision, means testing, the often notional right to choice in the matter, and ultimately some irreducibly difficult options. Bed blocking for beginners, I suppose, but someone's got to teach it.

Colin Douglas, doctor and novelist, Edinburgh