reviews

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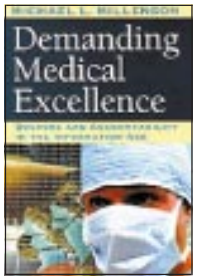
Demanding Medical Excellence

Michael L Millenson



University of Chicago Press, £19.95, pp 384
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Rating: ★★★

The US healthcare system consumes $1 trillion a year, which is equivalent to 14% of gross domestic product or roughly $4000 per capita (compared with about $1300 in Britain). Even so, Americans' life expectancy ranks about 15th in the world, infant mortality is higher than in most industrialised nations, and 44 million citizens have no health insurance. In short, say Drs Frank Davidoff and Robert D Reinecke in the 20 April issue of *Annals of Internal Medicine*, "the health care system in the United States is an embarrassing, world-class mess."

Enter Michael Millenson, a former reporter for the *Chicago Tribune* and now a healthcare policy consultant, to tell us what went wrong—and what might be done about it. The main culprit, he says, has been rampant overuse of medical services. He cites a Harvard University study which showed that a quarter of coronary bypasses, angioplasties, and catheterisations performed on elderly heart attack patients are unnecessary; he claims that as much as 85% of everyday medical treatments have never been scientifically validated; and he castigates an epidemic of iatrogenesis that is reckoned to yield 180 000 treatment related deaths in US hospitals every year. Physicians and hospitals have to learn to live with objective quality measurement and comparison, he says, as the gathering revolution in the everyday practice of medicine will owe more to laptops than to lab coats.

Millenson peppers his polemic with interesting and sometimes humorous historical allusions. For example, in England the Archbishop of Canterbury was officially empowered to grant medical degrees until 1840; Blaise Pascal first proposed the idea of using mathematical analysis to discern patterns of medical treatment in 17th century France; and in the United States in the mid-1930s a third of all operations performed under anaesthesia were tonsillectomies.

The author credits the randomised clinical trial, evidence based medicine, and "best practices" for helping to move medicine from an art to a science. Unlike most US doctors, the public, and the press, he also acknowledges the impact of managed care (which now includes 80% of Americans insured by their employers) in lowering the annual percentage escalation of medical costs from the teens to about 4%, for having curbed much of the excess medicalisation, and for making preventive medicine not just an ideal but a reality.

In a chapter titled "Trust me. I'm a Doctor" Millenson notes that "scientists, like ordinary mortals, tend to ignore evidence that contradicts what they already believe." Altering a scientific paradigm is traumatic and disruptive. The keys to medical excellence are information and accountability. "A system that has unhesitatingly deferred to the interests of physicians is beginning to listen to the preferences of patients. And a system that has defined quality by what doctors do is starting to assess care by how clinical interventions affect patients' lives."

David Woods, *president, Healthcare Media International, Philadelphia, USA*

On the History of Lunacy: The 19th Century and After

Edward H Hare

Gabbay, pp 176
ISBN 0953269906

Rating: ★★★

History, to quote Voltaire, is a trick the living play on the dead. All too often the trick involves myths about the past being used to buttress current theories or practices. By means of a conjuring trick, the wisdom of former times is shown to coincide remarkably with the interests of currently dominant groups. This approach, which suppresses variability or ambiguity, makes the past monolithic.

Edward Hare's work was quite at odds with such approaches. While much of the rest of psychiatry was mobilising authority figures from the past, in the face of onslaughts from the antipsychiatrists in the 1960s, Hare's historical work began to appear. Its common theme is that in the past things might have been radically different from how they are now. Hare pointed to the rise in the diagnosis of depression after the introduction of antidepressants and speculated on the effects of such secular processes on our understanding of disease entities. He argued that schizophrenia varied widely in incidence over time and proposed a viral aetiology as a possible explanation. He lifted the skirts of the godlike figures from the past to show their feet of clay by detailing their earnest arguments for masturbation as a cause of insanity.

This volume has been published privately in memory of Edward Hare and is sent free to colleagues, friends, and institutions. It contains his best historical essays published from a variety of sources. Hare was both a doctor and an eclectic researcher, with history being just one of his research interests. Not surprisingly, then, this is not a history of mentalities. He was interested in the medical details of other times—such as the erysipelas, pellagra, and tuberculosis which made detention in an asylum so hazardous. These are conditions that we now understand and have eliminated, but Hare also details conditions like "insane ear," which mysteriously flourished within asylums and later disappeared without our being any wiser today than we were then.

Hare's role for academic historians of psychiatry was to stimulate controversy. Before these essays, there was very little research on the history of psychiatry. His provocative theses on schizophrenia engaged historians such as Andrew Scull, transforming the history of psychiatry in the process into a vigorous and flourishing discipline. This is a volume that many people will be glad to have, written in a felicitous style that will also engage and retain the attentions of those who stumble across it by accident.

David Healy, *director, North Wales Department of Psychological Medicine, Bangor*

Doctors as gods

The BMA is the envy of other professional trade unions for its headline grabbing powers. The Law Society, the solicitors' professional body, produces worthy tracts—what's wrong with the law in this subject, ethics guides for solicitors in that subject—but its strike rate in the media comes nowhere near the BMA's. Perhaps lawyers are thought to have their own interests too much at heart. With doctors, there's no obvious link with money so they must be motivated by their patients' interests, mustn't they?

But wait a minute, what about that other corrupting motivator—power? Power, in this case, over life and death. Maybe doctors want to be God. That seemed to be the thought behind much of the media coverage of last week's guidance from the BMA ethics committee on withholding and withdrawing life-prolonging medical treatment. The BMA was giving doctors new powers to take life or death decisions, proclaimed the headlines, or doctors were taking the powers for themselves. "More life and death powers for doctors," said the *Daily Mail*'s headline, over a news story which began: "Doctors were effectively given greater powers yesterday to end the life of seriously ill patients."

So powerful is the BMA, it seems, that it can give doctors the right to decide whether patients live or die. "Doctors … this week condoned 'murder by starvation,'" claimed the standfirst to Ann Leslie's Saturday essay in the *Daily Mail*. Ms Leslie states: "If I murdered my husband (or indeed my late mother) by deliberately starving him or her, with the collusion of my doctor, on the grounds that depriving them of the basic human right to food and water was in their 'best interest', I apparently should be allowed to get away with it—without the sanction, overview or safeguard of a court judgment. That, in effect, is what the BMA's ethics committee report, issued this week, is recommending." She focuses on the report's statement that "artificial nutrition and hydration" can be withdrawn from patients on the decision of doctors alone, and that doctors should not "routinely be obliged to seek court approval before withdrawing" such nutrition. But this statement is based on the state of the law as it exists—a state for which the *Daily Mail*, ironically, bears a substantial share of the responsibility.

There is a huge gap in English law when it comes to taking decisions about treatment for adults who are incompetent to consent or refuse. The *Daily Mail*, through its "anti-euthanasia" campaign, has so far held off legislation, drawn up years ago by the Law Commission, that would plug the gap by setting up a framework for decision making. At present, there is no one who can consent or refuse on an incompetent adult's behalf—not relatives and not even the courts. Some of the newspaper stories implied that patients' families were to have the right to decide taken away from them and the decision given to doctors. In fact, families have no right to take a decision for an incompetent patient. Nor do the courts: all a court can do is make a declaration that

NEW ETHICAL GUIDANCE ON WHEN CARE CAN BE HALTED

More life and death powers for doctors

DOCTORS were effectively given greater powers yesterday to end the life of seriously ill patients.

By REEZY MARSH
Medical Reporter

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doctors would not be acting unlawfully in carrying out their own decision that treatment—which the court in the Tony Bland case decided includes artificial nutrition and hydration—should be withdrawn or withheld in the best interests of the patient. This is based on the doctrine that doctors may act in a patient's best interests without consent in a case of "necessity"—the only legal principle available to cover such cases in the absence of any mechanism for a relative or court to take the decision. It is the current law, not the BMA, which puts the ball firmly in the doctors' court. What is in a patient's best interests is for doctors to decide, not the next of kin—although they will have to be consulted because what the patient "would have wanted" will form part of the equation of best interests.

It follows that doctors cannot be obliged to go to court: they go for their own protection, for the comfort of the declaration that they are not acting unlawfully. In the Bland case the House of Lords had no legal power to compel doctors to go to court: when the law lords said that such cases should come to court that was no more than a recommendation, although one that doctors would be unwise to disregard until alternative mechanisms are in place. The principles that applied in the Bland case also apply to incompetent patients with medical conditions other than the persistent vegetative state. Indeed, the High Court has already declared that the withdrawal of nutrition and hydration is lawful in the case of a patient not in the persistent vegetative state according to royal college guidelines, and two further cases of patients not in the persistent vegetative state are poised to come to court.

The fact that no legislation has plugged the gap must be laid largely at the door of the *Daily Mail*. In 1993 the Law Commission produced a blueprint for reform of the law. The Conservative government planned to legislate, but the *Daily Mail* ran scare stories claiming that it would license doctors to kill off their patients. The government, which had taken a battering over its divorce reforms as a result of a *Daily Mail* campaign, backed off. The Labour government, too, believes that the reforms should be enacted but is just as nervous as its Tory predecessor. It has issued a fresh consultation paper outlining the reforms, virtually unaltered from the previous paper, which has already been exhaustively consulted on.

Clare Dyer, *legal correspondent, BMJ*

WEBSITE OF THE WEEK

www.treasury-projects-taskforce.gov.uk/intro/main.htm This week a paper and an editorial claim that the private finance initiative does not expand the public sector, but drains it of resources. The thinking behind the scheme dates from the Conservative era. You can read what is, in web terms, the ancient history of the schem, from 1992 to 1995, at www.hm-treasury.gov.uk/pub/html/finance95/main.html. New Labour has seized on the scheme with enthusiasm, or at least recognised that it is powerless to do anything different: more than 5000 civil servants were trained to operate the initiative in a scheme that was itself financed by public-private partnership in the early 1990s.

The Treasury website that outlines the scheme is an impressive illustration of the potential of electronic publishing to link relevant information sources together. Pages of policy peppered with the words "prudent" and "partnership" are linked to "OJECS," the *Official Journal of the European Communities*, which lists various capital projects open to tender. Companies that wish to compete for work can choose a link and download a detailed specification of, for example, Addenbrooke's Hospital's requirements for its new clinical information system. Although the government claims to have introduced a system in which unsuccessful contenders could learn why they had not been successful after the competitive bidding, the "expired OJECS" link did not work at all when I tested it, so it's hard to comment on how open and transparent the processes have been.

Naturally, there are no links here to opponents of the scheme. A quick word search on "back door privatisation" suggests that the Scottish National Party is leading the charge against the scheme, on the web at least (www.snp.org.uk/), but even that's just a press release.

Douglas Carnall
BMJ

PERSONAL VIEW

Starting back at the bottom

I have lost count of the times that people have told me that I must have been upset to give up surgery. It seemed that everyone who interviewed me thought that the surgical bug would eventually pull me back. I think after four years in general practice I can safely say that the move was one of the best decisions I have made.

I had always aimed at doing surgery, and three and a half years into senior house officer posts I was on a good rotation and had achieved the fellowship of the Royal College of Surgeons. But osteogenesis was winning. In the days of open cholecystectomies we used to guess the patient's weight by how many fingers I broke holding the liver retractor. I was furious on one occasion during my accident and emergency job when my boss sent me home after I broke my toe, in my view a minor injury. The final straw was a fracture round my elbow early in a three day weekend on call. Over a cup of coffee with my consultant the next day I talked myself round to the idea that the part of surgery that I found most fulfilling if I could not operate was talking to patients and their long term care, and so general practice was the right way to go.

I decided to do a complete training scheme partly because I did not think that I had enough experience of other areas of medicine, and partly because none of my surgical jobs was recognised for vocational training. Vocational training held many surprises, not least that my surgical experience was far better preparation for general practice than any of the training scheme posts. I was used to coping with uncertainty. The medical problems I saw in surgery were far more akin to general practice than were those in general medicine, where by definition we saw the problems that GPs could not sort out. Also, with a background in neurosurgery I had plenty of experience of and training in breaking bad news. It came as quite a shock on a new trainers' course earlier this year to find that out of 10 prospective trainers I was the only one with any training in this skill.

The hospital jobs were hard; suddenly I was back to being at the bottom of the pile. It came as a blow the first time in gynaecology when I was timetabled to be in theatre and was sent away to find a proper gynaecological senior house officer. Surgical problems were another bone of contention. It seemed a daft system that someone with non-gynaecological pain was sent home even if it was a barn door appendix. On one occasion a registrar did relent and let me relieve a patient of an inflamed appendix as he wanted to learn how to do it. In care of the elderly the consultant seemed willing to let me decide whether we could deal with a situation rather than call on a surgical senior house officer probably less experienced than I was.

But a lot of the hospital time and teaching was unhelpful. Making prospective GPs attend tutorials for higher professional exams and then calling this appropriate in-service training is far from adequate. Some posts were good at recognising the different needs; others definitely were not. At the end assessment of one post the only comment I got from the consultant was that my writing was awful.

I wonder how many juniors are put off a major career change by a feeling of failure in their previous specialty

Consultants' attitudes to GPs vary dramatically, and this has an effect on the juniors' willingness to accept referrals. I was impressed with one who told us senior house officers never to refuse an admission as the GP was always more experienced than us. The GP can also see the home situation, but may not be able to tell you on the phone in front of the patient. I have since made a very dodgy referral because I did not dare do a repeat home visit to a man in a house with pornographic pictures all round and a six inch knife under the bed. You can always ring back later if you do not understand a referral. It would be good for all doctors, no matter what specialty—even surgeons—to spend time as GP registrars.

Having reassured my trainer that I really did want to be a GP, I finally made it to a training practice and have never looked back. But I wonder how many juniors are put off a major career change by a feeling of failure in their previous specialty or because they had less sympathetic seniors than I had. It is easy not to realise what a specialty involves until you try it; even preregistration house jobs do not really give you a clear idea. At a time when doctors' stress levels are a major problem we should be making every effort to let juniors find the right area, even if it does mean a few false starts. Forty years in the wrong specialty is bound to lead to sick doctors.

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**

Judith Lindeck, *general practitioner, Bristol*

SOUNDINGS

Beastly handwriting

It has long been a widely accepted fact—especially among patients, nurses, and pharmacists—that doctors have far worse handwriting than most other so called learned professionals. Recent studies have largely confirmed this popular belief, one such study (1979) finding that 16% of doctors wrote quite illegibly and that another 17% were barely legible.

Why doctors should write so badly is not quite clear, and it is improbable that they are still trying to keep secret the contents of their prescriptions. Even more implausible explanations are defective toilet training and a collective "Disorder of Written Expression" (code 315.2). It is more likely that poor handwriting is caused by bad habits acquired while taking lecture notes in medical school; by excessive modern documentation requirements; or by just being too plain busy.

Good handwriting in the old days was achieved with ink dipping pens that smudged the paper and stained the fingers. Even fountain pens, though invented around 1884, were thought to be incompatible with a neat hand, and ballpoints were definitely the devil's invention. Many graduates nowadays eschew even these satanic instruments, having typed their essays in college or used laptops ever since first put in the playpen. Accordingly, a neat hand has become a rare phenomenon.

Illegible writing may result in dreadful medical mishaps, and while the future may well belong to computers and word recognition transcription machines, several institutions have tried to improve matters by offering remedial penmanship classes. Handwriting specialists have sprung up like mushrooms, some with their own website, some advising a change from the cursive baroque to the loop-free italic style with letters largely separate rather than joined. Others recommend going back to fountain pens, which tend to slow one down and thereby improve legibility.

Last year, on impulse, I bought such a device, a non-refillable disposable fountain pen, available in the United States and also in the United Kingdom. I have used these pens ever since, and also gave some to a colleague badly in need of them, with quite good results. I must say that unfortunately the clip tends to break off rather easily. Nevertheless, I can recommend these pens highly, as a modest means of achieving an extra modicum of legibility.

George Dunea, *attending physician, Cook County Hospital, Chicago, Illinois, USA*