FILM

The curious adoption of *John Q*

US health insurers seek to show that they really care

In *John Q*, a Hollywood blockbuster that topped the US box office on its opening weekend, it is not too difficult to spot the bad guys.

Denzel Washington plays John Q Archibald, a factory worker and regular guy who is doing all he can to support his wife and son. One day, the boy keels over while playing little league baseball, and only an emergency heart transplant can save him.

But there's a big problem. John's dastardly health insurers won't cover the costs of the operation. Unknown to John, his employer-sponsored health plan had been downgraded. The plan, says the hospital administrator, does not cover "a procedure of this magnitude."

Time is running out. And so the increasingly distraught father takes the emergency room hostage, demanding that the cardiac surgeon performs the transplant. Dad may not have a great health plan, but he has a fantastic gun.

Why has *John Q*, released in the United States on 15 February, captured the imagination of the American public? The tense hostage scenes and a gun-toting Denzel must have played a part. But perhaps, more importantly, the film's portrayal of the limitations of health insurance has touched a raw nerve.

"Half of Americans say they had a problem with their health plan in the last year," said Drew Altman, president of the Kaiser Family Foundation, which provides information on health issues to policymakers, the media, and the public. "Sometimes this problem is that the plan wouldn't cover health procedures."

Altman said that the movie was inaccurate in one major way. It suggested that the biggest problem with health plans was that they did not cover emergencies. But the main problem, said Altman, was that patients could not "get lots of small things covered and so their care is delayed."

But Altman believes that *John Q* was accurate in conveying one important truth. It was true, he said, that the public sometimes considered health insurers as "evil," even if it was employers—not insurers—who had set the limitations on health coverage. "The public," said Altman, "is angry with insurance companies, not with their [the public's] employers."

The film is likely to add to the backlash against these companies, by portraying them as greedy, uncaring, and responsible for obstructing vital medical care. How would the industry respond to the movie's disparaging message?

John Q, said the *Wall Street Journal* (14 February 2002), offered health insurers an interesting marketing question: "Should they ignore the movie, attack it—or seize on it to promote their own agendas?"

The insurers chose the last of these options, and did so in true Hollywood style. On the same day that the movie premiered, The American Association of Health Plans ran a full page, colour advertisement in Hollywood trade newspapers, and in the Capitol Hill paper *Roll Call*. The ad puts a major spin on the movie's message.

"John Q—It's not just a movie," said the ad, "it's a crisis for 40 million people who can't afford health care." Health insurers, of course, were not to blame.

Instead, the crisis was due to "rising drug and hospital costs," a "runaway litigation system," and "expensive government regulations." The ad pointed the finger at "some in Washington" for proposing "new laws that will make it harder for employers like John Q's to provide quality, affordable health care."

How health insurers put a spin on the movie's message

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Denzel Washington (left) as John Q has captured the American public's imagination

In the ad, the industry gave itself a pat on the back: "Sometimes it seems like health plans are the only ones trying to make health care more affordable." The ad sought to turn the bad guys in *John Q* into the good guys.

Defensive posturing? Not at all, said the association's president, Karen Ignani. "We're not being defensive here," she told the *Wall Street Journal*, "we're trying to shine a spotlight on the problem."

Mark Merritt, the association's senior vice president, told *the Washington Post* (14 February 2002) that he was "a huge Denzel Washington fan." It made sense, he said, for the association to adopt *John Q*, as a way of showing that health insurers do care about the uninsured millions.

This is not the first time that a Hollywood movie has attacked the US health insurance industry. In *As Good As It Gets*, for example, the lead character rages against her health insurer for obstructing her son's asthmatic care. But this is the first time that the insurance industry has advertised in showbiz papers.

The industry's glitzy adoption of *John Q* as a tool for its own political gain is a clever, if not transparent, piece of media manoeuvring. "The industry is artfully doing damage control," said Drew Altman.

Will the damage control be enough? This seems extremely unlikely, given that *John Q* confirms to the public its deep suspicions about health plans. "People are afraid," said Altman, "that the health plan won't be there for them when they are really sick." The industry ad will not be enough to calm the public's jangled nerves.

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A doctor's guide to Dr Foster

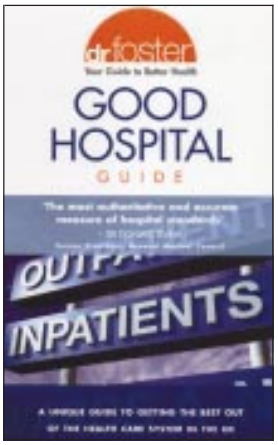
Behind the scenes at a company that measures healthcare standards

Over the past year the media has been awash with information about the relative standards of different hospitals and consultants. Some of this information, which is aimed at the healthcare consumer, has come from the government. But also riding high on the crest of this league table wave is a small private publishing company, Dr Foster, whose logo reads: "Your guide to better health."

The company may not yet be a household name, but it is certainly intent on creating a media impact. It has already published—last November—in association with the *Times* several consumer guides to hospital consultants. These guides were packed with region by region information about consultants in various specialties, including heart surgery and neurology. The Dr Foster *Good Birth Guide*—a 500 page compendium that the company boasts is "the only fully comprehensive guide to maternity services in the United Kingdom"—was published in January. But it is perhaps the Dr Foster *Good Hospital Guide*, due to be launched on Thursday 21 March, that is the jewel in the company's crown.

The *Good Hospital Guide* is subtitled: "The definitive guide to getting the best service from the NHS and private hospitals. First independent assessment of every major hospital in the UK."

As the government and the public demand greater transparency from the medical profession, particularly in response to things such as the Bristol Royal Infirmary inquiry, Dr Foster seems to be blessed with the right socio-political climate for launching its material.



So who are the people behind Dr Foster and what is the quality of their information like? It was set up in 2000 as an independent organisation by a group of people that included former *Sunday Times* news editor Tim Kelsey, who is Dr Foster's chief executive. Kelsey said that he was initially motivated to create Dr Foster after his wife had "a particularly horrendous experience in a maternity unit" which the couple felt could have been different had more information been available at the time.

The quality of Dr Foster's information has been a source of anxiety for healthcare providers. It is compiled from data provided by individual trusts and doctors, as well as from the Department of Health. Sir Brian Jarman, emeritus professor of primary health care at Imperial College and also one of the authors of the Bristol inquiry report, heads Dr Foster's research and analysis.

While some of the results have ended up in tables in the papers, Kelsey maintained that Dr Foster was not in the business of league tables. He gave the example of overall hospital mortality rates in areas such as heart surgery results and said that Dr Foster published "clusters. So we would identify outliers who are particularly above average or outliers who are particularly below average … rather than, you know, one, two, three, four, five, six."

In most cases, Dr Foster analyses five to six years of data and adjusts for variables, such as age, sex, length of hospital stay, method of admission, and case mix. Some doctors are concerned that the data does not adequately adjust for case mix, so that trusts or individuals that have a greater load of high risk patients may be identified as poor performers and become reluctant to take on high risk cases. Dr Foster's response is: "Our current research shows this is not an issue, but we believe it may become one in the future. We may need to improve data collection and develop analyses to account for this."

Another concern is the potential for scapegoating. The BMA has said it supports the publication of accurate information that will assist patients and GPs, but added: "We need to move away from a blame culture that assumes that if a patient cannot be treated successfully, the doctor or hospital must have been at fault." In other words, data that could be valuable for learning and improving practice could be harmful if used as a means of judgment.

Dr Foster is funded by venture capital and private investors and states that none of its investors has a commercial interest in health care. It prides itself on its independence. The company—which is run by journalists but which has an ethics committee full of big names and chaired by Dr Jack Tinker, dean of the Royal Society of Medicine—has been conducting a year long marketing and publicity campaign in the run up to the launch of the *Good Hospital Guide*. Its marketing plan says that "controversial material will guarantee publicity coverage across the media."

Martin Marshall, professor of general practice at the National Primary Care Research and Development Centre at the University of Manchester, said he thought Dr Foster served "an important role in terms of getting the whole issue of comparative performance data into the public domain. But the data isn't good enough to make definitive comparative judgments about the quality of healthcare. Their main contribution is that they are professional journalists and they know how to communicate information in a way that civil servants don't."

Ruth Little *BMJ Clegg scholar*

WEBSITE OF THE WEEK

Nosing around: Smells, as Liam Farrell points out in his column (p 553), have the power to blank out other sensations in our lives completely. This seems to be true even while just reading about them. And that's not only bad smells. A survey of people's favourite smells on the internet (http://dspace.dial.pipex.com/town/avenue/as07/yourniffs.htm) provides comprehensive lists, grouped under atmospheric, body parts, chemicals, commercial perfumes and scents, essential oils, flowers, food and drink, fruit, materials, medicines, miscellaneous, household objects, pets, and trees. And while cat's urine is not among those, rain soaked dog seems to do for some people what freshly lit matches, chlorine bleach, or photocopier smells do for others. Reassuringly, fresh cut grass, freshly washed hair, and roses are also included in the list.

It's a shame the internet does not offer scratch and sniff technology (although the scratch and sniff page at www.bright.net/~mamba/scratch.html may offer some surprises on that front), as some of the items listed seem on the slightly bizarre side.

A more scientific approach to the phenomenon of smells can be found at www.hhmi.org/senses/ (Seeing, hearing, and smelling the world, a report from the Howard Hughes Medical Institute). This describes the discovery of the odorant receptor proteins by two American scientists in 1991, explains how we remember or recognise odours, and how we sniff out sexual and social signals. For those who are particularly interested in the mysteries of odour in human sexuality, www.pheromones.com offers "an engrossing read on a whole new world under our noses."

The web based smells database of the chemistry department at Berkeley university in California, United States (http://mc2.cchem.berkeley.edu/Smells/index.html), lists what it calls "interesting smells." These include chemicals with disagreeable and agreeable sounding smells (hydrogen sulfide—smells of rotten eggs; beta-phenyl ethyl alcohol—smells like roses), complete with graphic representations and chemical attributes.

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PERSONAL VIEW

Prosecution or persecution?

It was a typically busy night in the regional neonatal intensive care unit. The nursing staff informed a junior doctor that an infant's intravenous cannula had "tissued." The doctor inserted a new cannula but, on attempting to flush the cannula with water, it was obvious that the cannula had been sited extravascularly.

While the doctor collected equipment for another cannulation attempt, the infant had a profound cardiorespiratory collapse from which he could not be resuscitated. An opened ampoule of intravenous phenytoin, intended for another patient, was found near to the deceased infant, raising the dreadful possibility that an erroneous administration of phenytoin had contributed to the infant's death.

The doctor who had attempted to replace the intravenous cannula was immediately suspended. The coroner was informed, police officers took statements from the attending staff, and post mortem analysis confirmed that the infant had received phenytoin. The Crown Prosecution Service (CPS) decided that the suspended doctor should be prosecuted for manslaughter.

The accused doctor was certain that he had not erroneously administered the phenytoin and he vigorously protested his innocence. However, being suspended, unemployable, and with his passport confiscated, he could only wait while the due process of the law proceeded painfully slowly. The fact that NHS trust indemnity does not cover criminal proceedings and the doctor did not have personal clinical indemnity insurance exacerbated the immense psychological and financial strain on him and his young family. Fortunately, he was eventually granted legal aid. More than a year later, the case was heard in the crown court.

As soon as the trial opened, the prosecution's case began to disintegrate when its main expert medical witness expressed grave misgivings and withdrew. Analysis of phenytoin levels systemically and within the various cannulae of the deceased infant indicated that it was most unlikely that the accused doctor had administered the drug. Four days into the trial, the prosecutor called the first of several nurses to present her account of the events leading to the infant's death. Under cross examination she refused to continue her evidence. With his case crumbling, the prosecutor declined to offer any further evidence, the judge directed the jury to return a not guilty verdict, and, at last, justice was done.

But had justice been done? The bereaved family's grief had been prolonged by futile legal proceedings, an innocent doctor's career had been devastated, and he and his family may never fully recover from the enormous strain placed upon them. Should this case ever have been allowed to come to trial? Crucial statements from the nurses involved were littered with inaccuracies, inconsistencies, and blatant errors of fact. There was disagreement over whether one of the nurses had tried to flush the deceased infant's tissued cannula. Accounts conflicted over which nurses had prepared, checked, and administered medications given to various infants that night. The timing of drug administrations differed between statements. Nor was there even agreement over which of the junior doctors had attempted to flush the cannulae of the deceased infant. Bizarrely, one of the nurse's statements carefully described the accused doctor's activities on the unit at a time when he had not even started to work that night.

Crucial statements were littered with inaccuracies, inconsistencies, and blatant errors of fact

It seems astounding that the CPS decided to prosecute the junior doctor on the basis of so many conflicting statements, and the eventual collapse of the prosecution's case was entirely predictable. To what extent had the prevailing climate of political and media near-hysteria concerning the perceived deficiencies of certain medical practitioners influenced the CPS? Was this actually a prosecution or a persecution?

There are lessons to be learnt from this unhappy episode. A lone member of staff should not be singled out for suspension when there is uncertainty over who has been responsible for a patient's death. Doctors must ensure that they are protected by personal clinical indemnity insurance in case they face criminal proceedings arising from their medical practice. Deficiencies in the working environment and systems often contribute to serious medical errors and it is highly contentious whether individual healthcare workers should be prosecuted for manslaughter in such circumstances.

Let us hope that the CPS will never again attempt to destroy the career of an innocent doctor

If, as in the case described, responsibility for a medical error is unclear, then the CPS would appear to be a completely inappropriate agency through which to try to resolve this difficult issue. Let us hope that the CPS has learnt this lesson and will never again attempt to destroy the career of an innocent doctor.

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SOUNDINGS

Bad smells are good

I'm pretty hardy, and not overly sensitive to bad smells; delicacy is not a virtue in this job. Humans can apparently distinguish up to 10 000 different scents, which is useful for docs, as every body fluid has its own distinct aroma, and when these have been percolating for a few weeks or more they can become a heady brew. Smegma, the stuff from infected sebaceous cysts, really stale urine, navel fluff that has been there for a generation, dead bodies, steatorrhoea, purulent phlegm, bad teeth—eight or nine pungent patients during an afternoon surgery on a warm day and the room becomes quite unforgettable.

Not all strong smells are unpleasant. Horse manure (or is it cow dung—can anyone tell the difference?) can be quite invigorating, a good honest reek, like going for a tramp across the fields, a whisper of the countryside to sweeten even the darkest and most bitter surgery.

Smells should indeed be our friends; open your arms and welcome them in. They are such a valuable form of non-verbal communication—for example, "You are only the doctor and not worth getting cleaned up for." They are also an intrinsic part of the diagnostic process, as with the patient who smelled as if he had been marinated overnight in cat's widdle. "Do you have a cat?" I asked shrewdly, sending off the toxoplasma titre. "How did you know?" he gasped. "Just a wild guess," I said, nodding sagely, like Sherlock Holmes patronising well meaning but bumbly Dr Watson.

Watson was no role model for me, I preferred Doc Holliday, lean, hungry, doomed, dangerous, decadent, and cynical though he was; he had that touch of fatal glamour, and I bet he smelled of whisky, cigars, and cologne.

Smell is more tenacious than the other senses; get it on your skin and even if you scrub and scrub and scrub you are not washing it off, merely spreading it around, like Lady Macbeth's dread spot. It is more resistant to time. When the catman left the room, though his corporeal body was gone, his presence yet hovered around me like a forlorn and stinky little ghost; the song was over but the memory lingered on, a gift to soften my regret at our parting, also to be savoured by other patients, who probably thought that I was the one with the cat problem. And if some of them did happen to gag, it certainly made them forget the complaint they came in with, which is practically the same thing as a cure, isn't it?

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