Letters

Target centred medicine

Targets can seriously damage your health …

Editor—Concerns about waiting lists and targets in the NHS are not new. They have been central to the experience and perception of our health care since its inception.[1] Nevertheless, Bogle's comments about the lengths to which some hospitals appear to go to meet targets should be taken seriously.[2] That targets and personal incentives influence managerial practices is not in doubt.

We observe that patients may be admitted to a medical ward for a few hours to wait for results of investigations. Such admissions certainly help throughput in accident and emergency departments. But they also increase paperwork and add to nursing workloads. It is perhaps ironic that such admissions may reduce average lengths of stay, another management benchmark.

Recent evidence has supported the view that a focus on particular targets may make clinical services worse. Harrad estimated that to meet waiting time targets for new patients, 25 patients with diabetes or glaucoma may have lost their vision due to a delay in their follow up appointments.[3] An analysis comparing the government's top performing hospitals with Dr Foster's research into death rates showed these hospitals to have higher than average death rates.[4]

We appreciate that it is easiest to manage measurable inputs and outputs. But when managing by target in a complex organisation such as the NHS, we think that greater care could perhaps be exercised in defining those few patient centred targets that unequivocally will make a difference for the better.

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Competing interests: None declared.

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2 Beecham L. BMA chairman criticises erosion of clinical autonomy *BMJ* 2003;327:8.
3 Gulland A. NHS staff cheat to hit government targets, MPs say. *BMJ* 2003;327:179. (26 July.)
4 Wright O. "Best" hospitals have the worst death rates. *Times* 2003, May 12.

… and fail patients too

Editor—According to MPs, NHS staff are cheating to hit government targets.[1] Many readers will not be surprised to read of stories of wheels being removed to rename a trolley as a bed, this problem has a more serious side. Through the use of punitive targets the government has tried to lead us from the gold standard of patient centred care to a new "target centred" brand of medicine.

The targets seem chosen for their ease of measurement rather than their clinical effectiveness. Where is the evidence base for these targets? Why is the same target used for a minor graze as for a polytrauma case? We have had numerous examples of patients being admitted purely to avoid breaching the four hour accident and emergency wait.

At best this has ended in an immediate discharge for an inappropriate admission, with all the attendant increase in costs and decrease in free beds. At worst the patient is transferred without the resuscitation and immediate treatment he or she needs. With such severe financial penalties associated with multiple breaches it is not surprising to hear these stories. As long waits in accident and emergency departments are due to understaffing, setting a magical four hour cut off will not improve patient care. We welcome MPs questioning the value of the targets. However, they should not accuse NHS staff of cheating to overcome the ludicrous targets they have set. The only people really being cheated are the patients.

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1 Gulland A. NHS staff cheat to hit government targets, MPs say. *BMJ* 2003;327:179. (26 July.)

The facts about franchising at Good Hope Hospital

See correction p 663

Editor—The brief news item about Good Hope Hospital does not reflect what is happening here.[1] We are disappointed that the *BMJ* should depart from its normal standards and mirror the tabloid press in making the story more important than the facts, which is inappropriate in a professional journal.

Good Hope Hospital has not been taken over by Secta. The franchising process has involved us signing a partnership contract with Secta, a consultancy with considerable health experience and part of the Tribal Group. This contract will run for three years and includes the provision of a chief executive and several specific actions that the trust board has deemed necessary to improve performance. The contract will be monitored by a subcommittee of the trust board, and the board will remain in control of the trust's direction.

Many NHS trusts employ consultants from time to time to help them improve the performance of their various hospitals. The trust is looking forward to a fruitful and productive partnership with Secta in a long term strategic relationship which might become a model for the future. Only time will tell, but the future success of Good Hope Hospital and the wider NHS certainly depends on the dedication and professionalism of its staff.

By referring to Good Hope Hospital as "No Hope" the *BMJ* serves only to perpetuate an untruth and demoralise a professional, dedicated, and hard working group of staff. That a respected medical journal saw fit to insult a group of NHS staff that have laboured under difficult conditions for many years is all the more distressing.

Clearly, as the *BMJ* has shown, ignorance about the franchise process and our hospital abounds. We ask therefore that it corrects the false impression that Good Hope Hospital has been taken over by a private firm and apologises to the staff for the jibe perpetrated in its unnecessary comment.

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Competing interests: None declared.

1 In brief. *BMJ* 2003;327:412. (23 August.)

Too many stars are bad for you

Editor—In her personal view Cardozo describes the contrasts between the NHS

and commercial medical interests and practice.[1] She feels "undervalued" and "demoralised" by her NHS work in contrast with commercial appreciation and success. I suspect that much of her problem comes from working in a three star NHS trust.

I work in a trust that has never had any stars. The management works hard to pursue priorities that are shared by patients, clinicians, and politicians. The outcome is that we feel valued and involved, even if there is a large measure of frustration. And we get no stars.

I suspect that to earn three stars you need to be blindly adherent to government priorities at the expense of other issues. Investing in your clinicians is an essential part of sustainable practice. Without enthusiastic clinicians today's stars may well be tomorrow's black holes.

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Competing interests: None declared.

1 Cardozo L. Contrasts. *BMJ* 2003; 327: 509. (30 August.)

Managing chronic pain in children and adolescents

Procedural sedation should be considered

Editor—Eccleston and Malleson point out the "vacuum" of treatment for pain in children during the time required for diagnosis.[1] This lack of attention to pain exists also for children with chronic disorders (such as inflammatory bowel disease, cancer, and rheumatoid arthritis) that often require repeated painful procedures (colonoscopy, lumbar puncture, bone marrow aspiration, arthrocentesis).

The need to perform sedation in children in this setting has increased notably, and deep sedation is required to achieve anxiolysis and immobilisation necessary for painful procedures.[2] Nevertheless, deep sedation is not routinely offered to children. In Italy no formal guidelines recommend deep sedation for oncological procedures and only the last guidelines of the Italian Society of Pediatric Gastroenterology recommend sedation for endoscopies.[3]

The lack of availability of anaesthesia resources, the risk of oversedation, and decrease in level of cardiorespiratory function limit the widespread use of this practice. Trials are ongoing to clarify the safety profile of different sedative drugs and to determine the settings in which non-anaesthetists may administer them,[4] and there is evidence confirming that trained staff can administer sedation safely in designated settings. In our experience, the development of a paediatric sedation unit with trained staff has allowed a notable improvement in the quality of care of patients, increasing the number of procedures performed with significant sparing of resources.[5] A comprehensive approach to the problem of pain in children cannot avoid addressing this issue and recommendations and guidelines are needed.

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Competing interests: None declared.

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Tethered cord syndrome should be considered

Editor—Eccleston and Malleson refer to the important and often frustrating topic of managing chronic pain in children and adolescents.[1] I reported a case of a 15 year old schoolgirl with chronic increasing pain (for approximately three years) of the thoracolumbar junction that extended bilaterally into the buttocks and posteriorly to the hip joints, with some intermittent bilateral pain around the lower rib cage laterally and anteriorly with some numbness in the legs and feet.[2] She had been diagnosed as having growing pains and was having difficulty coping with school work.

The possibility of functional tethered cord syndrome should be considered when adolescent patients present with unexplained lumbar, buttock, and leg symptoms. The diagnosis of functional tethered cord syndrome in this 15 year old patient's case was confirmed at surgery, when an L5 laminectomy was performed to section the filum to release the tethered spinal cord, the tethered filum spontaneously retracting cephalad. The patient did well at school and remained free of symptoms.

Suspicion of functional tethered cord syndrome should be considered in unexplained cases of vague lumbar and lower extremity symptoms and signs in adults[3] and adolescents even when repeated lumbar reports after magnetic resonance imaging state there are no features of tethered cord or other dysraphic disorder, laboratory tests are normal, and routine neurological tests for deep reflexes, plantar response, pinprick sensation, and vibration sensation are normal.

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1 Eccleston C, Malleson P. Managing chronic pain in children and adolescents. *BMJ* 2003;326:1408-9. (27 June.)
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Effective responses are possible with non-evidence based clinical practice

Editor—Eccleston and Malleson highlighted the embarrassing lack of data on managing chronic pain in children but also the apparent ignorance and confusion surrounding the topic.[1] Families, I agree, can be unnecessarily offended by labels such as psychosomatic, wrongly perceiving this to mean all in the mind if labels are misapplied, misunderstood, or not explained.

Owing to minimal evidence to guide clinical practice, considerable ignorance remains about psychological treatment other than "management" of chronic pain and psychosomatic conditions. Resolution by psychological means is a real possibility not accepted by many. Pain (and fear) must be investigated, managed, and treated appropriately—both medically and psychologically.

I agree that controlled trials with a focus on safety as well as efficacy are urgently needed. However, treatments that lack evidence from controlled trials should not be avoided. Effective responses are possible with non-evidence based clinical practice. Skilled clinical psychologists trained in research are precluded from this by waiting lists and other bureaucratic blocks.

Psychological treatment by trained non-psychologists can have good effect at low cost, but with notable caveats relating to whether treatments were effective for outcomes including disability, family, and school functioning and for those severely disabled by pain. Clinical and health psychologists (not necessarily in teams) are skilled in treating and developing new treatments for severe conditions, and family intervention is routine. However, reports of severe parenting stress or dysfunctional family roles should indicate neither causal nor directional relations. Referrals to skilled clinicians, able to evaluate and treat pain, cost nothing compared with managing lifelong pain.

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1 Eccleston C, Malleson P. Managing chronic pain in children and adolescents. *BMJ* 2003;326:1408-9. (27 June.)

Conundrum of the HOPE study

Time of taking ramipril may account for lack of relation between blood pressure and outcome

Editor—The conundrum of the HOPE (heart outcomes prevention evaluation) study is resolved.[1] Why was there no relation between blood pressure and outcome? Answer: Because ramipril was taken at bedtime.

Separate papers in the *BMJ* and *Lancet* reported that risk reduction for stroke and

cardiovascular end points in the HOPE study were much greater than could be accounted for by the small reduction in measured blood pressure.[2 3] Both papers suggested that ramipril had brought about a specific beneficial effect unrelated to blood pressure lowering. However, neither paper mentioned when the ACE inhibitor dose was taken in relation to blood pressure measurement.

A previous report by an overlapping authorship reported that HOPE "is the only large trial in which an antihypertensive agent, according to the study protocol, has been recommended to be given at bedtime" and that blood pressure was measured on the following day, between 12 and 18 hours later.[4] This report of 24 hour blood pressure monitoring on a subset of HOPE subjects confirmed that the bedtime dose of ramipril brought about a pronounced effect on overnight blood pressure (decrease of 17/8 mm Hg) but no significant reduction in blood pressure when measured the following day. The time course of action of ramipril was clearly demonstrated, with a peak effect between 3 and 6 hours after administration. The effect had waned by 12 hours after administration.

There is no reason to believe that the pharmacodynamics of ramipril observed in the 38 Swedish patients studied over 24 hours would differ appreciably from that of the rest of the subjects. This is so even though they were slightly older, had more vascular disease, and were taking fewer blood pressure lowering drugs than the rest of the HOPE study population.

Unfortunately lack of clarity remains. A subsequent letter by the authors stated that "in some people (but not all) ramipril was taken at night."[5] The authors must come clean. Just how many of their subjects followed the original protocol and took ramipril at night? What was the fall in office blood pressure in those who did take their treatment in the morning? Does this change the conclusions of their *BMJ* and *Lancet* papers?[2 3]

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Competing interests: None declared.

1 HOPE Investigators. Effects of an angiotensin-converting enzyme inhibitor, ramipril, on cardiovascular events in high-risk patients. *N Engl J Med* 2000;342:145-53.
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Authors' reply

EDITOR—Taylor speculates that the reason that the HOPE (heart outcomes prevention evaluation) study did not show a significant relation between blood pressure and outcome was because ramipril was taken at bedtime.[1]

We believe that this assertion is incorrect for several reasons.

Firstly, the population studied in the paper by Svensson et al differed substantially from the overall HOPE population.[2] This substudy focused on 38 patients who had peripheral arterial disease whereas only 43% of the overall HOPE population had such disease. Moreover, the patients recruited from the one centre participating in this substudy had blood pressures that were appreciably different from those in the overall trial (150/79 mm Hg *v* 139/79 mm Hg).

Secondly, even if a blood pressure reduction were extrapolated from the substudy by Svensson et al (which we believe is not appropriate), the degree of blood pressure reduction may at most be underestimated by 40%. With this taken into account, the blood pressure reduction between ramipril and placebo would be an estimated 4/3 mm Hg, and the effect on myocardial infarction still remains larger than that expected on the basis of epidemiological data.

Thirdly, studies that have assessed two different approaches to blood pressure—for example, the LIFE (losartan intervention for endpoint reduction in hypertension) study examining the effect of angiotensin receptor blockers *v* β blockers[3]—show that blockers of the renin-angiotensin-aldosterone system provide greater clinical benefit when blood pressure reduction is identical. Furthermore, other blood pressure lowering agents, such as calcium channel blockers, have been previously studied in populations similar to HOPE with no evidence of clinical benefit.[4]

Finally, the results of the HOPE study have now been confirmed by other large independent studies.[5]

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Competing interests: Both authors have acted as consultants and have received funding for research from the sponsors of the HOPE study, as well as having attended and presented papers at symposia with support from the sponsoring agencies. The HOPE study was funded by the Medical Research Council of Canada (now Canadian Institutes for Health Research), Hoechst-Marion Roussel (now Aventis), AstraZeneca, King Pharmaceuticals, Natural Source Vitamin E Association, Negma, and the Heart and Stroke Foundation of Ontario.

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Doctors may need to go beyond medicine in mental illness

EDITOR—Mike Shooter's narrative is remarkable for the fact that as a patient he developed his own form of treatment.[1] Implicit in his account is a recognition of the shortcomings of the medical model of mental illness.

Advocates for mentally ill people seek the removal of stigma. They emphasise the role of biology in generating the experiences of madness. They hope that seeing mental conditions as brain disorders and not as reflections on the sufferer's personal make up will alleviate shame and societal disapproval. As one advocate put it, "depression is something you have, not something you are." But Shooter finds benefit in saying "I have to challenge the assumptions I make." This implies a third way of thinking about depression and manic depression, not as something we are, not as something we have, but as something we do. This outlook deserves exploration.

I have written elsewhere about being picked up by police late at night wandering the beach in my underwear thinking I was Elijah the prophet, looking for the coming of the Messiah.[2 3] My sense of this incident, now nine years past, was that it was the most profound and meaningful healing experience imaginable; I had never felt more sane and purposeful.

Sometimes mania has an importance that cannot be captured by medical paradigms that focus on brain disorders. Biological models remove self knowledge and moral agency from the picture. Let us enlarge our frames of reference for manic depression, so we can remove stigma not just from the diagnosis of mania but from the experiences themselves.

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Competing interests: EW has no financial stakes here but never passes up an opportunity to pontificate on his favourite hobby horse.

1 Crane H. Depression. *BMJ* 2003;326:1324. (12 June.)
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Immunonutrition

Increased mortality is associated with immunonutrition in sepsis

EDITOR—The review by Calder highlights data from meta-analysis that propose a benefit from giving immunonutrition in critically ill patients,[1] but the current literature does not support this.

Recent publications suggest an increase in mortality in patients with sepsis who are given immunonutrition.[2 3] Interim analysis of a large, ongoing, multicentre Italian trial of immunonutrition showed an increased mortality in severe sepsis and septic shock.[3] This was even more alarming given that the control group was fed parenterally (associ-

ated with an increase in mortality in the critically ill) and had more unfavourable baseline characteristics (age greater than 60 and combined cardiopulmonary failure). These results led to an end to recruitment of patients with severe sepsis and a recommendation that the immunonutrient arginine should not be used in severe sepsis.

Probiotics (live microbial food ingredients of benefit to health) are also immunonutrients (as defined by Calder) and yet little recognition is given to their immune enhancing properties in the critically ill. Research in intensive care in this discipline is still in its infancy, but preliminary studies have shown a mortality benefit in diverse groups of critically ill patients.[4 5]

The benefits of immunonutrition in critically ill patients are yet to be realised. Different patients might require different immunonutrients during critical illness, and these requirements might change at different stages of disease. Probiotics should not become the forgotten relative of the more commercial immunonutrient cocktails.

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Competing interests: None declared.

1 Calder PC. Immunonutrition. *BMJ* 2003;327:117-8. (19 July.)
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Author's reply

Editor—In my editorial I said that the benefits of immunonutrition identified in meta-analyses are more pronounced in surgical than critically ill patients and that doubts remain about the efficacy of this approach in critically ill patients. I concluded that use of immunonutrition should be approached cautiously in most critically ill patients.

In addition, I highlighted that one trial showed significantly increased mortality in critically ill patients receiving immunonutrition, an effect that was more pronounced in patients with sepsis.[1] My statements and conclusions are supported by a recent review of immunonutrition.[2] At the time of writing my editorial (November 2002) the interim analysis of the Italian study was not published and so I could not consider it.

On balance, it appears that Knight and I are in agreement that benefits of immunonutrition in the critically ill are not yet realised. I certainly agree that different patients may require different immunonutrients during different stages of critical illness. This is what I alluded to in my conclusion that future efforts should try and define the most effective nutrients and optimal mixes for use in different patient groups.

I do not agree with Knight's statement that probiotics "are also immunonutrients (as defined by Calder)." This is because my definition indicates that immunonutrition involves the use of specific nutrients. Probiotics are not nutrients—they are organisms. However, I recognise that probiotics can modulate immune function and inflammatory processes,[3] and I accept that they may have a role in modulating host responses in surgical[4] and, perhaps, critically ill patients.

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Competing interests: PC has been reimbursed for attending or paid a fee for speaking at conferences by Baxter Clintec, B Braun, Danone, Fresenius, Nestlé, Nuteral, and SHS International and has received research funding from Nutricia.

1 Bower RH, Cerra FB, Bershadsky B, Licari JJ, Hoyt DB, Jenson GL, et al. Early enteral administration of a formula (Impact) supplemented with arginine, nucleotides, and fish oil in intensive care unit patients: results of a multicenter, prospective, randomized, clinical trial. *Crit Care Med* 1995;23:436-49.
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Human milk is still best

Editor—Over 10 years ago Barker et al postulated the hypothesis of fetal programming by showing that low birthweight babies had a higher mortality from ischaemic heart disease.[1] Subsequently, fast postnatal catch-up growth was found to be an additional risk factor for ischaemic heart disease,[2] showing that early childhood programming was as important as the milieu in the womb. The most important form of early childhood programming and the form most amenable to beneficial intervention is nutrition—particularly breast feeding, or the lack of it.

Forsyth et al studied long chain fatty acid supplementation in infant formula and later blood pressure in childhood, and their findings will no doubt greatly influence the strategies of infant formula companies for years to come.[3] However, the key finding should be that breast feeding does it all naturally, and for free. Sufficient evidence suggests that human milk, besides its role in preventing acute childhood infections, also protects against chronic diseases in childhood and beyond. The first commercially sold milk food for infants was formulated 136 years ago, yet the search for an ideal formula still continues.

Two years ago an article published in the *BMJ* raised considerable consternation when it implied that extending the duration of breast feeding beyond 3 months decreased brachial arterial distensibility in young adults and hence increased their theoretical risk of developing hypertension later.[4] To support their findings, the authors quoted another paper from Barker's group, which found that men who were breast fed and not weaned at 1 year old had a higher chance of death from ischaemic heart disease compared with those breast fed for less than a year.[5] What was not emphasised was that the same was true for purely bottle fed men. Human milk is the ultimate form of early nutrition for children, and the search for the ideal substitution infant formula will never be concluded satisfactorily.

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Competing interests: None declared.

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Stages of a man's life

The three stages can be expanded …

Editor—I can expand Charatan's three stages of a man's life[1]:

He believes in Santa Claus
He doesn't believe in Santa Claus
He IS Santa Claus
He looks like Santa Claus.

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Competing interests: IRW is extremely busy on call every 24 December.

1 Charatan F. The three stages of a man's life. *BMJ* 2003;326:1242. (7 June.)

… and further expanded

Editor—An expansion to Charatan's and Wakefield's stages of life[1]:

He believes in Santa Claus
He doesn't believe in Santa Claus
He IS Santa Claus
He looks like Santa Claus
He acts like Santa Claus.

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Competing interests: JHL is heading to the middle stage.

1 Charatan F. The three stages of a man's life. *BMJ* 2003;326:1242. (7 June.)