reviews

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Rebuilding Trust in Healthcare

Eds Jamie Harrison, Rob Innes, Tim van Zwanenberg

Radcliffe Medical Press, £27.95, pp 224
ISBN 1 85775 938 9

Rating: ★★★★

What is the Real Cost of More Patient Choice?

John Appleby, Anthony Harrison, Nancy Devlin

King's Fund, £6.50, pp 64
ISBN 1 8571 7473 9

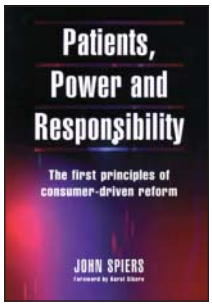
Rating: ★★★

Patients, Power and Responsibility: The First Principles of Consumer-Driven Reform

John Spiers

Radcliffe Medical Press, £27.95, pp 272
ISBN 1 85775 924 9

Rating: ★★★



Where have we gone wrong in medicine? The respect that doctors took for granted has evaporated; medical gods have been reduced to mere mortals. We no longer trust the caring general practitioner, the wise physician, or the conscientious surgeon. And it all seemed to happen so quickly. A litany of medical mistakes, hospital mismanagement, misinformation, subterfuge, and murder has dragged the medical profession through the tabloids and into the mire. Maybe we deserve it.

Dressed in a bland cover and damned with a boring title, *Rebuilding Trust in Healthcare* is anything but. It tells it as it is. Compelling as any thriller and unbelievable if it were not true, it leaves the medical reader with a profound sense of shame, embarrassment, and perhaps a little guilt. For old fashioned believers in altruism and the vocational concepts of medicine, this book is bleak reading. While Bristol, Shipman, and Alder Hey are familiar in a vague sense, this book is frightening because it spells out the facts. And the truth is we have failed our patients. It is a blunt message: "Medicine will have to say it is sorry for past mistakes and mean it."

If true friends are those who have your best interests at heart, then the book's contributors—Rabbi Julia Neuberger, the bishop of Liverpool, Ruth Etchels, Rob Innes, and John Newton—are among them. They are supportive of doctors, but make some harsh criticisms, and we should take note. There are some positive observations and suggestions about improvement. I would like to believe them. Part of the problem is that we don't listen enough to others. We should ask ourselves how medical school turns wide eyed enthusiasts, whose declared interest is in helping others, into a cartel who listen to few and are strangled by self belief.

The serial killer Harold Shipman was clearly a nice doctor, well liked by his patients. But being a nice doctor is not enough if we are not good doctors. At Alder Hey—where children's organs were removed and stored without parents' knowledge—the pathologist Dick van Velzen erred, but many others in the university and health service turned the other way. If we reflect on our own careers, we too might recall an error, mistake, or indiscretion covered up. If those who blew the whistle over substandard paediatric cardiac surgery at Bristol Royal Infirmary suffered, can we be sure that we would support a system of reporting underperformance that is fair to all? But times have changed. And if you ever doubt it, it is a salutary reminder that the families' feelings were so strong that doctors and hospital administrators were asked not to attend the Alder Hey church ceremony. It will be a long road back.

Perhaps the King's Fund booklet *What is the Real Cost of More Patient Choice?* might offer some reassurance. Surely patients will choose a good doctor who will care for them as a person? No. Although written primarily as a discussion paper in a series on policy analysis, this book offers further insight into the erosion of the primacy of the physician. The power of professionals has traditionally been because of their exclusive access to information, but the wider availability of information on the internet and elsewhere has eroded this power. Informed choice increasingly places the power with the patient. As prescribing rights are handed over to nurses, and other treatments become deregulated, doctors will have a different role.

This book focuses on the fascinating implications of patient choice, but does not shirk from potential conflicts with equity, efficiency, and quality. It uses cardiothoracic surgery as an example, but the principles are widely applicable. What is important, according to the subtext, is that doctors deliver a service and that the person who really matters is the patient care adviser, usually a nurse. The conclusion, however unpalatable, must be that the personal qualities and personality of the doctor matter little. Doctors are technicians delivering a service.

John Spiers, formerly chairman of the Patients Association, is even more explicit. His text, *Patients, Power and Responsibility*, is a whirlwind of ideas, quotations, suggestions, and soundbites. It is overwhelming at times, but the message is clear. Spiers advocates giving power to the individual: patient fundholding with quality measures so that patients can make informed choices. He seeks a cultural change, where the main challenge is to break the power of the professional. He points out, for example, that "governance is not the answer because it generalizes the challenge and sidesteps the necessity to scrutinize individual practice. We must each be accountable for our own clinical practice." Spiers believes the public should know about the performance of specific doctors and teams and units within hospitals. And he points out that doctors already know to whom we would recommend our family or friends. It is easy, therefore, to appreciate the argument that information on outcomes at hospitals or in general practice should be available.

Believing in the importance of personal, primary, and continuing care, I can sense the discomfort, even anger, of many hardworking and caring colleagues. Doctors are human. But if these three books offer an insight into the future, there are tough times ahead.

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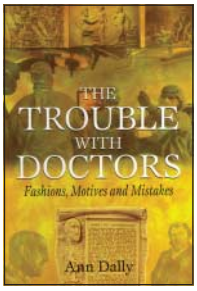
The Trouble with Doctors: Fashions, Motives and Mistakes

Ann Dally



Robson Books, £16.95, pp 239
ISBN 1 86105 373 8

Rating: ★★

Every generation of doctors needs a book that makes us stand back from the edge and question what we do. For me it was Peter Skrabanek and John McCormick's *Follies and Fallacies in Medicine*. For previous generations it was Ivan Illich's *Limits to Medicine* that rattled the cage, though neither book is as funny as the 100 year old tirade in the preface to George Bernard Shaw's *The Doctor's Dilemma*. I was hoping Ann Dally's book would be the latest addition to a satirical audit trail going back to Molière's *Le Malade Imaginaire* and before, but it doesn't quite fit the bill.

The trouble with *The Trouble with Doctors* is that most of us think we know the answers already. Everyone oversells us, including ourselves. Politicians impose absurdly unrealistic timeframes for untested reforms; the drugs industry seeds the media with stories of wonder drugs of marginal benefit; patients won't accept the inevitability of disease and death; and it's a brave surgeon who'll admit to being below average. And in our blame culture if you don't get it right first time in under five minutes you'll be splashed all over the *Sunday Mercury*.

The ethicist David Seedhouse defines health as the extent to which what is expected of us matches what we achieve, and by that measure doctors are unhealthy from just about every angle. No wonder so many are in brain meltdown. Yet medicine has progressed enormously in the last 50 years—so why is nobody celebrating? Dally reaches the same conclusion that we all do: unrealistic expectations.

Her contention is that such expectations have arisen because we have failed to appreciate the central role of fashion in medicine and the variability between doctors, not just in ability but in belief and desire. The book has an interesting chapter on motivation—how doctors act in their own interests as well as those of patients—but we're too quickly into the territory of Shipman and Eichmann before she offers the disclaimer, "Killing patients for pleasure or relief of tension is probably extremely rare." But her end thought—that doctors are human, and we need to get real about their motives—is wise enough.

The bulk of the book is dedicated to fashion: how essential it is for progress but also how often it leads us down blind alleys. All medicine starts with fashion, hoping that evidence will arrive in due course, and Dally documents all our worst excesses, from lancing gums to whipping out an elongated uvula. So, will evidence based medicine ride to the rescue? Sadly not. "This is another fashion, and will eventually be shown to be so," she says. So why are we no longer whipping out uvulas?

Dally sees a difference between evidence (a good thing) and evidence based medicine (a fashion), but she doesn't clearly articulate this difference. There's plenty of fascinating historical context but no new concepts. Everything here was said by Shaw a century ago, in fewer words and with more humour. Even the bit about uvulas.

Phil Hammond *writer, comedian, and resting doctor, Bristol*
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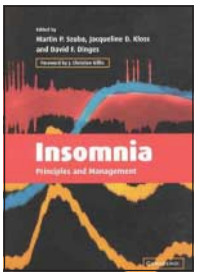
Insomnia: Principles and Management

Eds Martin P Szuba, Jacqueline D Kloss, David F Dinges



Cambridge University Press, £34.95, pp 306
ISBN 0 521 01076 4

Rating: ★★★★

Sleep—a state marked by lessened consciousness, lessened movement of the skeletal muscles, and slowed-down metabolism—has an essential restorative function and an important role in memory consolidation. It is an orchestrated neurochemical process involving sleep promoting and arousal centres in the brain. Sleep propensity depends on two main factors: the amount of accumulated sleep deprivation and the circadian clock phase enhancing sleep at night.

Insomnia is a symptom, resulting from insufficient sleep or sleep of poor quality, with negative effects on subsequent daytime functioning. The prevalence of insomnia increases steeply during the fifth decade of life. People with insomnia often complain of impairments in attention, memory, or concentration, impairments in their mood, feeling depressed or irritable or anxious, and impairments in their ability to function at work, at home, or even at school. They generally have more medical complaints, seek medical care more often, and are more prone to road injuries than people without insomnia.

An enormous gap exists between the prevalence of insomnia and the actual management of people with the condition. While roughly 20% to 30% of adults worldwide get insomnia, less than 50% of them will be diagnosed as having the condition. Patients are hesitant to discuss insomnia with their doctors because they are afraid that their problem will be seen as trivial or indicate a serious illness. Doctors tend to trivialise insomnia because little of their medical training is devoted to it and because they are often unaware that the onset of insomnia may signal a serious condition or an established risk factor for psychiatric illness.

Insomnia: Principles and Management announces the arrival of this complex sleep disorder at the frontiers of internal and sleep medicine. With contributions from highly prominent sleep specialists, this multi-authored volume captures the breadth of the field and introduces a diverse array of up-to-date scientific and clinical data ranging from the diagnosis, prevalence, aetiology, and management of insomnia to the neurobiology of sleep and arousal. It also provides several perspectives on related disorders, such as circadian rhythm sleep disorders in sighted and blind subjects, jet lag, and mood disorders.

The book reviews the various approaches for the management of insomnia, including behavioural approaches, the use of hypnotic drugs aimed at treating sleep quantity deficits, and the use of chronobiotic drugs (biological clock effectors, such as melatonin and its analogues) to improve the circadian control of the sleep-wake cycle. If indeed melatonin plays a role in sleep regulation, either through its chronobiotic, soporific activities or both, we would expect that exogenous melatonin administration will be able to induce sleep during daytime or when the homeostatic drive to sleep is insufficient, and to improve sleep in cases where there is a deficiency in endogenous melatonin. This is indeed demonstrated in blind subjects, delayed sleep phase syndrome, and elderly patients with insomnia in whom melatonin production is diminished.

Another important contribution of this book is the effort to identify where research should be heading. In recent years, the focus of clinically oriented sleep medicine has shifted from sleep quantity to sleep quality, as quality rather than quantity is associated with impaired daytime functioning, anxiety, depression, fatigue, and poor quality of life.

This succinct and informative volume will be useful to both sleep experts and general practitioners alike.

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Competing interest: NZ is involved in the development of melatonin for the treatment of insomnia.

NETLINES

- Memory Book (www.memorybook.co.uk) is a patient oriented information booklet designed to help people with memory problems—for example, people with Alzheimer's disease or those who have had a head injury or some trauma to the brain. The book, which has been written by a senior clinical psychologist working with older adults, includes sections on "how to keep the grey matter in working order" and how to make life predictable and memorable. It can be downloaded free of charge and can be used for individual or voluntary group purposes.
- The internet has some nice sites about electrocardiograms (ECGs), and www.madsci.com/manu/indexekg.htm is certainly worth a visit. This page, which is effectively a hypertext index to a large number of ECG topics, functions like a short textbook. The first section in particular, "What is an ECG," is well worth a visit for those seeking a back to basics approach to ECGs. This site is ideal for new learners or older heads wanting to revise.
- Sometimes it is easy to forget that there is a world of science out there that is vital to the continued progress of medicine. Science Daily (www.sciencedaily.com) may help doctors keep abreast of what is happening. In addition to the latest news on the home page, it is possible to search more than 15 000 stories. New visitors are advised to read the "about this site" section, which explains who is behind Science Daily and how they obtain their material.
- The British Chapter of the International Association for the Study of Pain has produced pain rating scales (www.painsociety.org/pain_scales.html) to assist in the assessment of people who do not have English as their first language. The scales are available to download as PDFs in a wide range of languages, such as Albanian, Mandarin, and Swahili. The page has been designed for primary care and emergency departments, but I suspect that many other specialties will also find these documents useful.
- www.fellows.rcsed.ac.uk/personal/jbarrie/hyperbook/conditions/Default.htm is worth checking out for a good review of some common conditions affecting the foot and ankle. This UK based resource is laid out in a simple index style, with topics ranging from plantar fasciitis to hallux rigidus and sinus tarsi syndrome. Clicking on to the links to the home page and then to the hyperbook will take you to a good section on history and examination in foot and ankle surgery.

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We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address.

JOURNALS

PLOS Biology

An open access online journal from the Public Library of Science; first issue October 2003

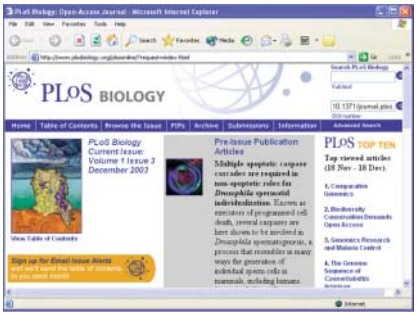
ISSN 1544 9173
www.plosbiology.org

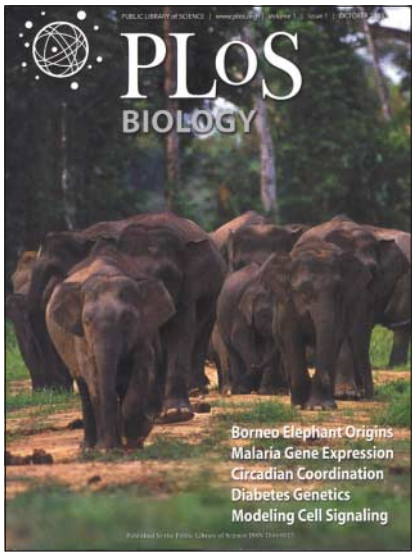
Rating: ★★★★

What an extraordinary time it is in scientific and medical publishing. These pages and many others have documented the increasing tension between traditional publishers and their audience in recent years. The essence of the problem is that readers have become dependent on easy-to-search, universally accessible electronic archives, which are owned by publishers, unlike old printed copies. If institutions stop current subscriptions, they also lose access to old issues. Publishers therefore seem to be free to charge what they like for access—and there is a perception that some are exploiting this position to the limit. Large profits from the publication of scientific journals have been reported.

Several initiatives to break out from this have involved establishing a different model of publishing, in which there is no charge for access to published papers. Instead, authors or their host institutions are charged pre-publication. Inevitably these initiatives have been primarily electronic, for reasons of cost. But the kudos accrued by publishing in the established journals, and the requirement for high impact publications, has slowed their development. BioMed Central is the largest of these initiatives, currently with 107 online journals. It has been strongly supported by some institutions, including UK universities and the NHS, which will pay publication costs for their authors. Unfortunately it has not yet attracted much high-impact science or medicine.

The Public Library of Science (PLOS) was born from a high-profile movement of academics and authors who in 2001 attempted to pressurise publishers to make all articles unconditionally free within six months of publication. Publishers did not oblige, so PLOS moved to the next stage, creating its own journals using this model. *PLOS Biology* is the first. It is freely available to all over the internet. Costs of production are met by a publication fee of several hundred dollars. More than BioMed Central, articles look as if they come from a paper journal, attributed to a specific issue and with page numbers. There are also short reviews of recent research in various areas, often of topical interest, and a promising "unsolved mystery" section.





Brave new publishing world: the print journal and, below, the online version

Well, how good is it? On the basis of the first two issues, it is very good indeed. There is a fascinating mix of commentary, short review articles, and full scientific research papers. The research articles are of impressive quality and relevance, covering, for example, malaria and diabetes genes, neural development, T cell signalling, and circadian rhythms. This feels like a really serious, well produced and high-science general biology journal. You will want to read many of the short articles and look in detail at some of the scientific ones. Such browsing is easier with a paper copy, and you can get one for a reasonable $160 (same price for institutions) for 12 issues. It is worth doing so, as it looks great.

On this evidence there seems a real prospect that *PLOS Biology* could be mould breaking, if it can maintain this scientific quality. It deserves to succeed. *PLOS Medicine* is due to launch in 2004.

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Items reviewed are rated on a 4 star scale (4=excellent)

PERSONAL VIEW

The death of the white coat?

The subject of white coats attracts varied and sometimes trenchant opinion. As one of those doctors who will never need to wear one again, I have to say that I feel indifferent about their significance. One of the reasons for my apathy is that if the coat was ever distinctive in any way I cannot see that it is now. The stark reality for proponents of white coats for doctors is that most modern hospital staff wear them regularly, and doctors probably least so. Take a look around and you'll see that it's quite a fashionable item. The woman in charge of the kitchens, the phlebotomist, the laboratory assistant, the blood porter, the electrocardiography technician, the pharmacist, the podiatrist, the dietician, and of course sprightly first year clinical students (enamoured of the mystique and novelty of the garment) all don the great white symbol.

Of course the white coat is not always the order of the day. General practice and other community based doctors have "white coat exemption." Curiously, most specialties beginning with the letter "p" also seem to qualify: public health doctors, psychiatrists, paediatricians, and, more rarely, the occasional pathologist could all pass for civilians at a glance in any hospital canteen.

The white coat dates back to the 19th century. Initially worn to prevent cross contamination (although a recent study showed that a quarter of white coats worn by doctors in a general hospital carried *Staphylococcus aureus*), the doctor's laboratory coat gradually became an icon of authority and healing. Improvements in medicine at the time meant that people were starting to be cured in hospitals rather than just dying. This, as well as the connotations of the colour white (see any dictionary), helped to create the almost sacred image of the garment. In the United States many medical schools have a formal robing or white coat ceremony when the students enter the school, which is usually attended by family and friends. This shows just how sacrosanct the coat is in a country that in many ways is similar to our own.

So why are some doctors so keen on the white coat? There are surely many factors beyond simple preference. I personally didn't like the coats, because they made me too hot, but I knew when it was wise to ignore my own comfort. I will never forget overhearing a professor of surgery who sent a locum senior house officer away to the linen room to get a white coat before he was allowed to join his ward round—even though the professor was clad in a bespoke chalk stripe wool suit. Funnily enough, no one felt the need to quiz the professor about quite when or how he had qualified for white coat exemption. Perhaps he was paying tribute to one of his rather suavely dressed colleagues in psychiatry? Certainly, doctors in surgical specialties can justify wearing white coats more easily than others, and evidently they do seem to wear them often. No one wants to get blood, pus, bile, or urine over their clothes, after all, not to mention faeces or vomit.

HULTON GETTY

Is there something authoritarian, even intimidating, about such a uniform?

Even though there is something instantly recognisable and predictably professional about a doctor in a white coat, it can act as a communication barrier between doctors and patients. Is there something intrinsically authoritarian, even intimidating, about such a uniform? I am not sure that the white coat makes doctors any more approachable. Some may not see this as a problem, of course.

What does the future hold for the white coat? Its role seems to have changed over the years and is now a source of confusion more than anything else. Once the white coat was a defining feature—an unmistakable characteristic that was the very means by which to positively identify the doctor—but life is not so simple now. On occasion during my job in casualty the pharmacist had to apologise to patients when they approached her with the words "Excuse me, doctor"; while I, in an open necked shirt, would be confused for a minicab driver. I suppose, in equal measures, her white coat and my customary lack of one were to blame.

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SOUNDINGS

Endless evaluation

I have just been going through some hospital notes on a case. There were, of course, pages and pages of necessary documentation of drugs given, fluids, results, and clinical findings. More distressing were the huge volumes of paper work taken up with entries such as the following: "Problem—maintaining patient dignity. Plan of action—local and national codes to be adhered to." This was then followed by a handwritten note stating, "Dignity maintained." There were numerous other examples: "Problem—patient in pain. Plan of action—assess patient's pain, administer analgesia, assess result." Beside this was handwritten, "Patient's pain assessed."

When I started as a trainer in general practice the necessary documentation I had to provide of a trainee's competency was a signature on a form and a date. This was, possibly, a little Spartan if I subsequently had to justify my decision. But now the assessment process—and, more importantly, the documentation of that process—takes a huge proportion of the time available for training. I spend much less time teaching and much more time documenting everything that I do.

The same is true of my practice of medicine. The process of documenting what I do, as opposed to doing it, takes an ever increasing fraction of my time. Personal development plans are a particular bugbear of mine. Any decent doctor has spent his or her whole career reflecting on their practice. To be forced to spend time documenting this in a PC format seems patronising and a complete waste of time. The idea that a bad doctor will become a good one by writing a reflective diary is frankly ludicrous.

It is obvious that assessment of performance and competency is important. But evaluation must be done sparingly. It is expensive in time and resources.

I think that all Department of Health apparatchiks should be forced to write out the following a thousand times: "Excessive evaluation harms patient care. Do not introduce more of it unless there is some evidence of benefit." This useful task would mean that those in the NHS who don't see patients will waste less of the time of those who do.

When they have finished their lines they should memorise the following old chestnut for a test: "You do not make a pig fatter by weighing it."

Kevin Barraclough *general practitioner, Painswick, Gloucestershire*