OPEN FORUM

What to cut: readers' suggestions

In his "On the Contrary" column three weeks ago (*BMJ* 2009;338:b1457) *BMJ* deputy editor Tony Delamothe invited readers to submit their own suggestions for saving on the NHS budget. Here are edited highlights from some of the responses

Stop quangos and targets

A good place to start would be the private finance initiative, practice based commissioning, Payment by Results, Choose and Book, NHS Direct, Modernising Medical Careers, the National Programme for Information Technology, "redisorganisations," management consultants, and the regulatory quangos that no one understands and that get renamed regularly to disguise their dysfunction. Then how about losing most targets and also the compliance officers needed to police or fudge the figures?

And is revalidation an evidence based treatment for an accurately diagnosed disease?

Peter G Davies, GP principal, Keighley Road Surgery, Illingworth, Halifax

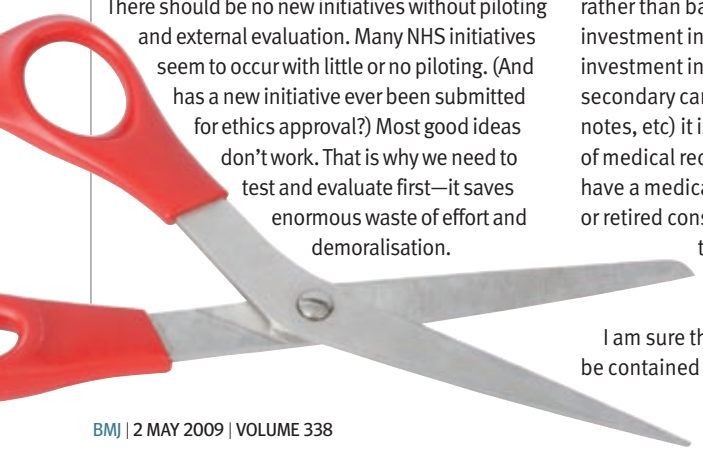
End the internal market

In the early 1990s we created a whole new structure, which split NHS institutions into purchasers and providers. This is delightful for managers because they immediately underwent replication and needed larger numbers and larger salaries as more chief executives were created. The whole thing was a child-like emulation of the private sector (where a lot of the new managers were to spend time learning their new ropes). It divided GPs from hospitals, health authorities from everybody, and hospitals from each other. Competition turned out not to be who could provide the best service most cheaply and efficiently but who could manipulate the rules to squeeze the most out of the system. It is a horrible, costly, and divisive system.

Leonard Peter, GP, Harrow

More piloting; cease incentives

There should be no new initiatives without piloting and external evaluation. Many NHS initiatives seem to occur with little or no piloting. (And has a new initiative ever been submitted for ethics approval?) Most good ideas don't work. That is why we need to test and evaluate first—it saves enormous waste of effort and demoralisation.



Secondly, cease financial incentives. Don't treat medical staff as if they were City financiers who respond only to cash. Medical staff are interested in patient care and ways they can improve that, and financial incentives distort this.

Paul Glasziou, professor of evidence based medicine, University of Oxford

Let doctors manage their affairs

As an outsider who observed the NHS in the early 1990s during its different waves of transformation I feel that one striking aspect was the wholesale induction of various management gurus tampering with medical practice. It was strange to see doctors being lectured on how and what they were supposed to do in rendering patient care. What the managers in North America and in the UK have not realised is that medical professionals are capable of surmounting various barriers that have been artificially created by management consultants and experts. It is the patients who suffer from such tampering.

Seshubabu Gosala, chief medical officer and port health officer, Port Area, Visakhapatnam, India

Limit the maximum salary for all staff to £150 000 (€170 000; $220 000) or five times that of the lowest paid staff in the NHS

Measures to reduce litigation

As a former NHS consultant, now in full time private practice, I am dismayed at the exponential increase in expert witness requests over the past few years. Many of the cases I see arise as a result of failure of systems, poor record keeping, and poor communication with patients rather than bad surgical technique. Despite investment in information technology and investment in new ways of arranging notes in secondary care (care pathways, multidisciplinary notes, etc) it is often difficult to make any sense of medical records. I think all hospitals should have a medical records committee run by senior or retired consultants and GPs to improve this aspect of medical care and to provide a rapid response to complaints.

I am sure that the huge cost of litigation could be contained by simple measures and attention to detail by senior medical staff.

Helen Parkhouse, consultant urological surgeon, King Edward VII Hospital, London

GP partners, not employees

Can I second Des Spence's suggestion in the same issue (BMJ 2009;338:b1420) that the payment structure for GPs should be changed to encourage young doctors to become partners rather than salaried employees. It is hardly rocket science to know that people work harder, are happier, and are more involved if they work for themselves or an ideal rather than for someone else.

William D Jeans, former GP and radiologist

Limit salaries

I would close down the purchaser-provider split, close down strategic health authorities and many quangos, remove most of the targets, and stop the private finance initiative. I would also limit the maximum salary for all staff to £150 000 (€170 000; $220 000) or five times that of the lowest paid staff in the NHS. If people will not work for this amount they are not the sort of people we need in the NHS.

Christopher Burns-Cox, consultant physician, Wotton-under-Edge, Gloucestershire

Who pays for treatments?

All urgent treatment and all obstetric and paediatric care should be paid for by the Exchequer, as now.

For all elective treatment and non-urgent advice there would be a charge ranging from 0% of cost for cancer surgery to 100% for cosmetic surgery, wholly on the patient's decision, with (say) three intermediate levels of charging.

For treatment deemed to be not "cost beneficial" by the National Institute for Health and Clinical Excellence, copayment should be charged to the patient according to means and need.

A new national insurance fund should be set up, owned by the individual and raised through his or her contributions, plus an annual state allowance, to cover copayments.

Richard B Godwin-Austen, retired neurologist, Southwell, Nottinghamshire

All responses and competing interest statements can be seen at www.bmj.com/cgi/eletters/338/apr07_1/b1457.

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ETHICS MAN **Daniel K Sokol**

The death of DNR

Can a change of terminology improve end of life care?

In a scene in the film *Dumb and Dumber*, Lloyd Christmas, played by Jim Carrey, sees a fellow diner collapse in a restaurant. The man clutches his abdomen and complains of an ulcer. "It's OK," Christmas reassures the victim, "I know CPR." The man resists mouth to mouth resuscitation. "It's a lot easier if you just lay back," Christmas notes.

While perhaps not quite as ignorant as the well meaning Christmas, many non-clinicians hold rosy views about the nature and effectiveness of cardiopulmonary resuscitation (CPR). Several studies have underlined their misplaced optimism: in one, the 269 respondents reported a mean expected survival rate for CPR of 65%[1]; in another, 81% of respondents over 70 years old believed the likelihood of leaving the hospital after a cardiac arrest to be at least 50%.[2] The real figure, for all in-hospital cardiac arrests, is roughly 14%, and many survivors will have new functional or neurological impairments.[3]

The illusion of CPR's effectiveness can lead patients and relatives to make ill informed choices about care at the end of life. To emphasise the fallibility of the exercise, many institutions have abandoned the term "do not resuscitate" (DNR) in favour of "do not attempt resuscitation" (DNAR). Still, the discussion about the suitability of a DNAR order can be difficult for patients, relatives, and clinicians alike. So awkward can it be that many such discussions, which should form an important component of the future care plan, are avoided entirely.[4]

Although raising the issue of death is seldom easy, part of the struggle is to dispel misunderstandings about DNR orders. DNR does not mean "do not treat," much less "do not bother." With the exception of those in intensive care, many patients with DNR orders survive to discharge. DNR means "if the patient has a cardiac arrest, do not attempt cardiopulmonary resuscitation." Some trusts now use the acronym DNACPR. The manner in which the situation is described is arguably more important in resuscitation decisions—when tension, fear, and guilt may be palpable—than in any other area of medicine. To help dispel myths and improve understanding, a further change of terminology has been suggested: "allow natural death" (AND).[5]

A study published earlier this year on the views of nurses, nursing students, and laypeople in south Texas showed that changing the title from DNR to AND increased endorsement of the order in all three groups, reaching statistical significance in the second two groups.[6] It is not a surprising result, given the gentler, more benevolent tone of "AND." It is devoid of the cold negativity of "do not resuscitate," with its connotations of abandonment and a death sentence. AND better reflects what so many of us believe should happen when the bell tolls: the peaceful, unobstructed flow from life to death.

Adopting the change should help reduce stress and feelings of guilt among all parties and may encourage clinicians to initiate the discussion with suitable patients or relatives more often than they currently do. The situation where patients who should have had a DNR order are resuscitated and are left on the ward, in a hopeless condition, to die a second time should become less frequent. Not only will the indignity of CPR on the inexorably dying occur less often, but the finance managers, recognising the potential savings of fewer days on the ward, should rejoice at the likely cost implications of the change.

There are problems with AND, not least the potential for mistaking AND with the conjunction "and." In the early days of implementation we should follow the example of one US institution that used AND/DNR to accustom staff to the new terminology.[5] Once the new acronym is widely known and the DNR part can be dropped, we should find a way to distinguish AND from its more pedestrian homograph, perhaps by circling the term or some other method.

"Allowing natural death, understood literally, may require withholding or withdrawing all sorts of treatment from the patient: no ventilation, no antibiotics, no dialysis, no palliation. Yet, often it may be appropriate to treat a DNR patient therapeutically"

AND lacks the specificity of DNR.[7] Allowing natural death, understood literally, may require withholding or withdrawing all sorts of treatment from the patient: no ventilation, no antibiotics, no dialysis, no palliation. Yet, often it may be appropriate to treat a DNR patient therapeutically.[8] If the term is introduced, we must determine exactly what we mean by it to avoid misinterpretation. AND, like DNR, does not necessarily entail forgoing aggressive treatment; and admittedly this fact does not sit comfortably with the literal interpretation of "allow natural death." As with DNR, any discussion of AND would be accompanied by a discussion of what care should and should not be offered. The vagueness of AND, rather than being a disadvantage, could encourage clinicians to have that discussion with patients and relatives.

As Hippocrates noted many years ago, clinicians should try to benefit patients with minimum harm. If a change of terminology can improve end of life care by reducing anxiety and costs, then surely such change is morally desirable, if not perhaps morally obligatory. The immediate priority is to identify, as exhaustively as possible, the logistical and practical challenges of making the transition from DNAR to AND—and to address them. We have much to learn from those pioneering institutions in the United States and the United Kingdom that have already effected the change. While changing the language alone will not overcome all the problems with resuscitation decisions, it is a step in the right direction, towards a healthier relationship between patients, relatives, and clinicians and a more peaceful end for many.

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References are on bmj.com
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