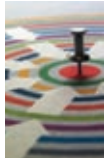


VIEWS & REVIEWS

Target overload,
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REVIEW OF THE WEEK

Health care USA: don't make a drama out of a crisis

A new book that promises to lift the lid on the US medical system offers little more than a soap opera, finds **Jerome Kassirer**

Despite the fact that many if not most people have had some experience of hospital, it is a safe bet that few have much more than a fleeting notion of how a hospital or medical centre is organised and functions. Julie Salamon had an unparalleled opportunity to paint a realistic picture, enlighten the public, and dispel confusion, given that she had unfettered access to anyone in Maimonides Medical Center, a large hospital in New York, for an entire year. The hospital is a large, highly rated, exceptionally busy institution. Every year it discharges tens of thousands of patients and treats well over 100 000 out-patients. It not only has origins in the orthodox Jewish community (and still serves it) but exists in a most atypical environment of multi-ethnicity and multiculturalism, requiring translators in dozens of languages. Merely describing the institution is challenging.

US hospitals are amazingly complex, and it's a minor miracle that they function at all. Many countries look to the US as a model for their own institutions. Let this essay be a warning: be cautious in adopting what we do.

In US medical centres patients with illnesses of mild or moderate severity no longer populate the beds: many hospitals now resemble huge intensive care units. The throughput—the patient flow—is astonishing. Length of stay varies from a few hours to a few days; and when a patient departs, the bed sheets barely have a chance to reach room temperature before a new patient rests her head. Emergency departments are overflowing, and they dare not turn anyone away without a well defined excuse. Doctors come and go; a single patient can end up, even in a short hospital stay, being under the care of a dozen or more physicians, and this trend of fragmented care and of “hand-offs” from one team to another continues to accelerate as house staff and senior staff physicians become shift workers, as the supply of generalists ebbs, and as multiple specialists are called in to manage care.

Hospital operations require hundreds of thousands of transactions every day. Aside from the critically important task of meticulously keeping track of every test and every treatment for every patient, avoiding every conceivable error, getting each patient to the proper location at the right time, and efficiently running something like a huge hotel requiring dozens if not hundreds of different menus, hospital executives are buffeted by constituencies, customers, suppliers, and regulators. Billing for each

service, diagnostic test, disposable, and use of equipment is a huge burden but a necessity for financial viability. Hospitals do not bill a single insurer but two or more federal agencies and several insurance companies, and to each they must provide detailed documentation of the care delivered.

Cost and the “bottom line” are always at the top of the agenda of the leaders of our medical centres. Although nearly all medical centres in the US are not for profit, they must make a surplus to provide the capital necessary for maintaining their facilities, building new programmes, and competing in the marketplace. But cost is only one of their everyday issues: the number and intensity of the constituents with a vested interest in the institution's performance sop up time and energy.

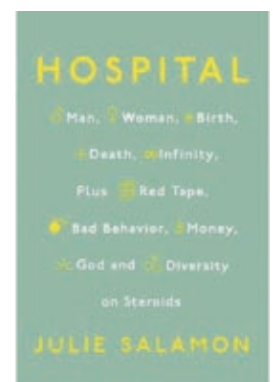
My warnings to those who might emulate us in the US are based on our perverse incentive system. The need to compete in the marketplace often moves our institutions in the wrong direction. It forces them to out-advertise their competitors, develop unsustainable research institutes, install the latest proton beam accelerator, become ever more specialised, pirate busy practitioners away from neighbouring hospitals, and develop financial deals with the drug industry that can come back to haunt them. Our ponderous billing mechanisms smother our administrators and challenge their capacity to meet expenses. We are not likely to escape from this milieu: powerful political and economic interests eagerly maintain the status quo.

In the US many patients emerge from their beds not fully understanding who had been in charge of their care, what was done to them, or why their bills were so gigantic. Our weekly television offerings of hospital soap operas with their bizarre stereotypes are several stretches from reality.

Salamon had a chance to explain the reality of how hospitals function, how staffing needs are met, and how administrators manage big medical institutions, but she too opts for drama. We get a picture of management personalities, special influences, petty bickering, and big egos and gain little insight into what a hospital is like. A hospital is much more than a collection of personalities.

Jerome P Kassirer is distinguished professor, Tufts University School of Medicine, Boston, Massachusetts jpkassirer@aol.com

Cite this as: *BMJ* 2008;337:a946



Hospital: Man, Woman, Birth, Death, Infinity, Plus Red Tape, Bad Behavior, Money, God, and Diversity on Steroids

Julie Salamon

Penguin, \$12.49, pp 363

ISBN 978-1400157242

Rating: ★★☆☆

In US medical centres patients with illnesses of mild or moderate severity no longer populate the beds: many hospitals now resemble huge intensive care units

Lessons from polyclinics in Central and Eastern Europe

PERSONAL VIEW **Bernd Rechel, Martin McKee**

For anyone from the former Soviet bloc—and there are quite a few doctors from the new member states of the European Union now working in the United Kingdom—the current discussion about the introduction of polyclinics in the English NHS must be utterly perplexing. Polyclinics were a centrepiece of the Soviet model of healthcare delivery, but many countries of Central and Eastern Europe have abandoned them over the past two decades in favour of a system of general practice that draws extensively on the British model. Advisers from the World Bank, the EU, and many bilateral donors agreed that the polyclinic had failed to deliver modern, integrated health care and saw general practices as the future. How can it be that England is now introducing a model that countries in Central and Eastern Europe were so recently encouraged to give up?

Although there is still considerable debate about what English polyclinics might look like (*BMJ* 2008;336:916-8), they will share with their predecessors in Central and Eastern Europe the fundamental characteristic of uniting primary and specialist services in a single location. Soviet polyclinics provided outpatient care for populations

in a specified geographical area (a so called medical district),

employed general physicians (so called therapists) and various specialists, and were affiliated to a particular hospital. They were concentrated in urban areas, where they were the first point of contact with the health system and the main provider of primary health care. Children and adults attended separate facilities, staffed by different doctors. Care was poor, with salaries low and facilities and equipment outdated. This model was replicated throughout the Soviet sphere.

Despite their limitations and a widely held view that the concept was outdated, polyclinics have proved remarkably resilient. Most countries of the former Soviet Union simply retained them, although some merged facilities for children and adults. In contrast, the former Soviet satellites in Central and Eastern Europe, now members of the EU, have mostly shifted provision of primary care to independent family doctors contracted with national health insurance funds or health insurance companies. Yet in many cases, the change has been limited. Many polyclinics remain open, although now sometimes in private hands or as not for profit enterprises. Some countries, such as Latvia, have simply redesignated them as “health centres,” while in Bulgaria they are now called “diagnostic consultative centres.” Often, independent doctors rent the rooms and equipment from the polyclinic where they had once been state employees. Furthermore, these general practitioners had often trained as specialists but have since had relatively short retraining courses in family medicine. This means that, in some cases, patients continue to see the same doctor in the same building as in the communist era.

The situation in Germany is of particular interest. After reunification in 1989, the polyclinics in the former East Germany were phased out, with the last one closing in 1995. Forced to become independent, many private doctors rented rooms in former polyclinics, sometimes investing their own funds to re-equip them. While avoiding the term polyclinic, the German government reintroduced the concept under the name

Medizinische Versorgungszentren (medical care centres) in 2004. As in England, the government hopes that this will improve cooperation between primary and secondary care, while reducing costs.

What lessons does this experience offer for England? One possibility is that the polyclinic model in Central and Eastern Europe is popular with patients and staff, bringing real benefits in bridging the gap between primary and specialist care that are difficult to replicate with a more dispersed network of general practitioners. This would argue in favour of the current English proposals. However, another is that health care manifests “path dependency,” whereby the starting conditions act as a constraint on what can be achieved. From this perspective, it is difficult to change the way in which doctors have trained and worked for many years, and this may prevent the anticipated benefits of closer collaboration from being realised.

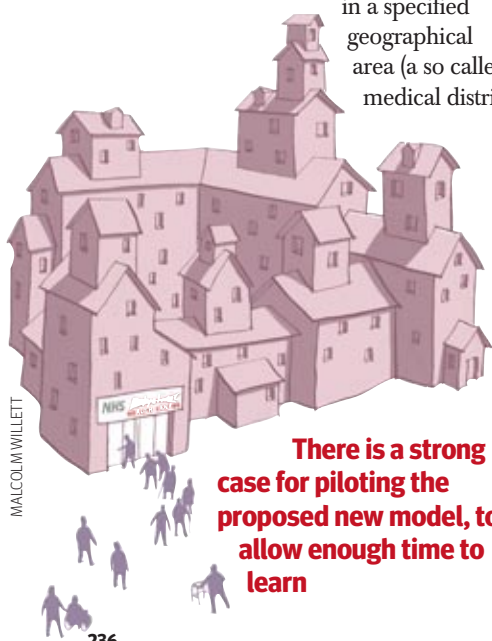
Either scenario is possible. However, change will incur substantial costs, both in the construction of new facilities and, much more importantly, in the organisational turmoil that will ensue. Furthermore, while greater provision of specialist services outside hospital may improve patient access, quality of care may decline, and costs may increase. There are also local specificities. Many English hospitals are now funded through private finance initiative schemes, so even if specialist services move out, they may still have to be paid for.

When introducing an idea that has been tried elsewhere, it is important to draw on relevant experience. There is a strong case for piloting the proposed new model, to allow enough time to learn. Unfortunately, as the past two decades have shown, that is not how things work here.

Bernd Rechel is honorary lecturer, London School of Hygiene and Tropical Medicine, London WC1E 7HT
Bernd.Rechel@lshtm.ac.uk

Martin McKee is professor of European public health, London School of Hygiene and Tropical Medicine, London WC1E 7HT

Cite this as: *BMJ* 2008;337:a952



There is a strong case for piloting the proposed new model, to allow enough time to learn

“All of the great physicians and scientists have questioned accepted dogma and often been reviled”
Medical classics, p 239



Harms of target driven care

PERSONAL VIEW **Nigel Rawlinson**

I went to listen to a senior member from the Department of Health explain the new “dogma” of target driven health care to our hospital’s consultant group. This was in 2005, as we were coming to terms with the fact of targets and with their use to drive healthcare performance. After her slick presentation I asked how the government was going to measure the harm that these targets would do to patient care. I remember being amazed at the skill with which that question was not answered.

From 2003 to 2006 I was associate clinical director of the emergency department at the Bristol Royal Infirmary. I soon realised that targets were here to stay, and led the unit to accept this and work with them. The phrase “I treat patients, not targets” was consigned to the past. We had to engage with the targets that had been set, and use them to attract the resources we needed to treat patients faster. We had a philosophy in the department that was forward thinking, aiming to find solutions rather than identify problems. The trust recognised this and supported us, and we met the 98% “four hour target” in 2006.

Two years on I believe that the harm these targets have done to patient care is becoming evident. Target driven care has undoubtedly changed the way we practise. However hard we try to remain patient focused, meeting targets is now the predominant driver. We are seeing that good staff, when made to work flat out to meet a deadline, will treat the clock rather than the patient. Of those patients being admitted, most leave the emergency department in the final 20 minutes of the four hour target period (*BMJ* 2005;330:1188-9). An internal audit was revealing. A cohort of patients who went to various outlying wards and who subsequently required management from the intensive care outreach team had left the department just before four hours. Without this time pressure they may have stayed longer, their condition made more stable better stabilised, and then transferred to a more appropriate clinical area.

A patient’s history has changed from one that strives to be holistic to one that is problem solving. A patient with chest pain is rapidly classified into “admit” or “discharge” categories,



SAMIMAGES/FOTOLIA

and “cardiac” or “pleuritic” decision routes.

Our ability to listen as medical staff is being challenged. There is now less time for the vulnerable, frightened, and inarticulate patients, who become objects of annoyance rather than subjects of care. It is instructive to stand in our clinical area and listen to the different assessments coming from behind curtains. We hear conversations in which open questions designed to help patients articulate their story are being replaced by closed, leading questions to categorise the patient into a convenient group.

More subtle assessment is lost. When I started in emergency medicine one of the hallmarks of the assessment of any patient with injury or illness was to discern “the story behind the story.” Patients presented with one problem and then, having had the relief of analgesia, diagnosis, and care, would tell the story behind the story. This often revealed domestic violence, exploitation, and danger. Our inner city emergency department made regular referrals to housing, employment, or social services. This practice has now virtually ceased; there is no longer the luxury of time to practise such holistic care. The tragedy is that these patients are often vulnerable and need time to trust.

Another victim of targets is the subtle diagnosis. Targets encourage patients to be categorised into management pathways. The patient who doesn’t quite fit and should alert the astute clinician to

something unusual, perhaps a rare diagnosis, is now more of an irritation than a fascination. In short, our ability to practise good medicine is undermined by the pressure of time.

It is my belief that targets, while achieving a great deal in terms of resource and timeliness, have done this at the expense of holistic patient care. Targets detract from the pursuit of clinical excellence. I agree that we have more doctors and nurses. I agree that we no longer have patients on ambulance trolleys for hours waiting to be seen, or going to sleep overnight in the minor end waiting room. This is, however, a totalitarian argument in which the health economists argue that patient care for the majority has improved. We as doctors need to be the advocates of the individual in front of us at that time. That certainly is what the patient expects, and to compromise that for the sake of the majority is therefore poor patient care.

I have not considered here the increased stress to staff who work in the “cauldron” of acute care and receive regular requests to “work even harder.” Nor has it considered the change in working practice and environment that makes teaching more difficult.

So, what of the future? A two hour target is now being proposed for emergency medicine. This will stir up controversy, but the momentum is there. It will happen, I fear. We must, I believe, ask questions of this. I accept that doctors are resistant to change, but sometimes that resistance is for good reason. Given the harms of target driven health care, it is surely wrong to introduce another more complex target into an already pressured emergency healthcare system.

The instigators of change need to listen to the professional healthcare workers on the front line who provide care and to report this back. The problem is that the present regime is so set in its self belief that this is unlikely to happen. It reminds me again of the government representative who so expertly ignored my question three years ago.

Nigel Rawlinson is consultant in emergency medicine, Bristol Royal Infirmary, Bristol BS2 8HW

Nigel.Rawlinson@ubht.nhs.uk

Cite this as: *BMJ* 2008;337:a885

Another personal view about NHS targets was recently published on bmj.com: see *BMJ* 2008;337:a195

Reveille

FROM THE
FRONTLINE
Des Spence



One morning on the Costa Brava: drunken singing fills the campsite; plasters float in the swimming pool; lobster coloured flesh and regretted tattoos are on show in the communal shower block; children hover around the campsite supermarket—sadly, it is British youth buying bottles of vodka. My only respite is Sebastian Faulks's first world war narrative, *Birdsong*.

Holidays are a type of home leave—a stepping out of the medical trench. You wonder if you can go back to it all: the prefab concrete health centre dugout, with blue lights in the toilets; the bombardment of initiatives, the sniper fire of complaints—all pointless and wasteful advances into no man's land, amid the fear of being caught in the barbed wire of media "investigation." Our political generals are at a comfortable distance, surveying outdated social maps with little thought for the real conditions at the front. Our war is fought to a rigid rule book of social engineering and political correctness.

The truth is that, despite the supposed heroism of medicine, we are left collecting the body parts of society. Initiatives on cholesterol and osteoporosis are of no consequence when we are faced with the rampant

infectious diseases of alcohol, drugs, teenage gangs, street violence, and communities drowning in the mud of the no-work benefit culture. There seems little point talking about family break-up, as the notion of the family seems defunct. We live in a blasted society. What are we to do? Announce another inquiry, employ another think tank, or launch more over the top initiatives?

From the vantage of the frontline there is an obvious counterweapon to address street violence and knife crime. Alcohol is being consumed at stronger concentration, at younger ages, and it ignites much of this violence. Current licensing laws are clearly not preventing alcohol reaching our children. In the aftermath, broken glass crunches underfoot; regrettably, it comes from alcohol brands typically sold through local corner shops and off-licenses. If we truly want to stem the haemorrhage of our young, we need some radical rethinking—but most of all we need some political bravery. The time has come to limit access to alcohol by revoking the alcohol licences of all community shops.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk
Cite this as: *BMJ* 2008;337:a940

Not a silly story

DRUG TALES AND
OTHER STORIES
Ike Iheanacho



UK researchers: beware the end of July. With it comes the onset of the long summer recess of parliament and, therefore, the media's "silly season." MPs disappear for extended holidays (sorry, "fact finding missions"), leaving the country to struggle on, somehow. The resulting lack of political initiatives, relaunches, analysis, speculation, and gossip means that other, supposedly more trivial, items are freer to jostle for coverage. Cue the reporting of medical studies that might not otherwise cut it as stories.

Yes, the season presents more opportunities for research to get noticed—but also to have it lampooned as too esoteric ("Look what they've wasted money on"), unnecessary ("Now tell us something we didn't know"), or a direct contradiction of previous evidence ("Why can't scientists make up their minds?").

Of course, some research is too important to rubbish. Such is that in *The Counterfeiting Superhighway*,

a report published, sensibly, early this month by a body called the European Alliance for Access to Safe Medicines (*BMJ* 2008;337:a618). This document is a worrying exposé of potential dangers in buying prescription only drugs from online pharmacies.

Although it's well worth reading, the report has key weaknesses. In places it seems to offer only grudging acceptance of the value of the internet, with overdone rants about those who choose to misuse it. Thus we're told about the "dark recesses of the internet"; fakers of drugs are "among the worst type of online predator"; and many of their customers are "poorly educated or misguided."

A particular gem is the assertion that "the unregulated online trade of medicines is a back door left ajar for counterfeiters to weasel their dangerous, illicit wares into the hands of phony online customers." No doubt the hyperbole aims for emphasis, but actually it just grates.

In any case, the research doesn't need overhyping: measured, clear, and succinctly presented, it offers a compelling picture, through a combination of desk research to assess and order from a sample of online pharmacies and subsequent analysis of the products obtained.

The findings are bad news. For instance, 90% of pharmacies would not require sight of authorised prescriptions to supply prescription only drugs (a necessity for legitimate operators); and fewer than one in six were traceable to a verifiable physical address. Only 38% of "medicine" samples were genuine branded products (some of which had been illegally imported from outside the European Union). And so on and on.

Thankfully, this crucial study steered clear of the silly season. If only enough people will now take it seriously.

Ike Iheanacho is editor, *Drug and Therapeutics Bulletin*

iheanacho@bmjgroup.com

Cite this as: *BMJ* 2008;337:a919

Success stories

In literature, if not in life itself, a person who is a failure is a more interesting character than one who is a success; and those who are without moments of self doubt are likely to be terrible, one dimensional bores. No success can, or perhaps should, ever quite assuage our existential anxieties. As a famous medical student, John Keats, once put it:

“Ay, in the very temple of delight/Veil’d Melancholy has her sovran shrine.”

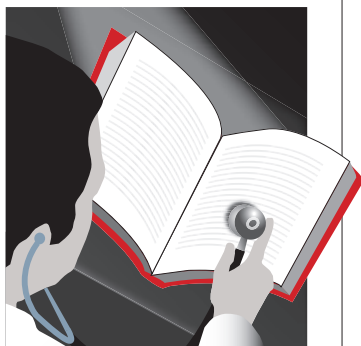
Sir Henry Harris (born 1925), one of the pre-eminent medical researchers of the second half of the last century and

regius professor of medicine at Oxford University, has written a collection of short stories in his retirement, entitled *Remnants of a Quiet Life*. Written in the first person, they explore the nature of worldly success and its relationship to genuine merit. A linguist before he was a doctor and scientist, and a cultivated man of the world, he must in his time have met more than his fair share of well known people, including charlatans and mediocrities.

He writes so well, so naturally, and so precisely that it is as if we are witnessing for ourselves everything that he describes, by his side as it were. In one story, “Fraud,” we learn about a PhD student who is so anxious to satisfy his mother’s ambition for him that he decides on a short cut to scientific fame. Disaster is only just averted; it is a sign of the merit of the writing that we feel compassion for the culprit and are glad that he is not publicly exposed.

In another story, “Dead Wood,” genuine intellectual achievement is contrasted with the kind of self promotion and bureaucratic manoeuvring

BETWEEN THE LINES
Theodore Dalrymple



Will any medical student now alive write in 60 years’ time as elegantly as Sir Henry?

that, increasingly, is a precondition of fame and worldly success. In an understated way, and without stridency, Sir Henry lets us know that he has seen the future, at least of Britain, and that it belongs to the apparatchiks.

In “The Order of Names” the narrator is confronted by a dilemma when he discovers that a well known scientist whose obituary notice he has agreed to write appropriated his most famous discovery from a disorganised and unknown but brilliant foreign student, who is now

also dead. He shouldn’t lie, of course, but must he tell the whole truth? Must he prevent an institute being named after the scientist who more or less stole another man’s idea?

Not all the stories concern science and the laboratory. One of them, “Paris in the Spring,” is a denunciation of the cultural vandalism of the 1968 revolt in Paris, all the more powerful because the protagonist, a scholarly medievalist, is initially sympathetic to the rebellious students. Although steeped in history, she forgets that revolutions devour their children and spends the declining years of her life, having been forced out of academic life, lamenting the culture that has been so wilfully destroyed. The narrator visits her tomb, which is neglected though only a few years old. A kind of low grade barbarism has triumphed.

As I read these elegiac stories, a question ran through my mind. Will any medical student now alive write in 60 years’ time as elegantly as Sir Henry?

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2008;337:a877

MEDICAL CLASSICS

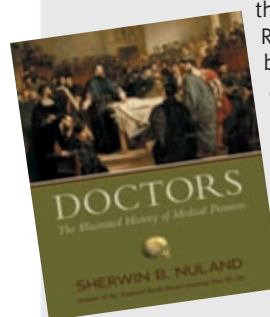
Doctors By Sherwin Nuland

First published 1988

In *Doctors* Sherwin Nuland, a surgeon and medical historian, explores the lives, thoughts, and the making of those physicians who he thinks have contributed most to the state of medicine today. These doctors are generally associated with the greatest conceptual advances in their respective fields. They include Hippocrates, Galen, and Vesalius; Ambroise Pare, for making surgery humane; William Harvey, for his use of the experimental method in medical research; Giovanni Morgagni, for showing the relation between clinical symptoms and the pathology of organs; John Hunter, who made surgery into a science; René Laennec, for inventing the stethoscope; and Ignac Semmelweis, for the germ theory.

The 20th century is represented by William Halstead (surgery and education in the United States), Helen Taussig (paediatric cardiology), and those who contributed to the field of transplantation. Thus, one sees a transition from a European (Italian, French, and British, and finally German) to an American hegemony in medical research.

Nuland is scholarly yet immensely readable. In *Doctors* he recreates the contemporary sociopolitical currents and puts the medical beliefs of the times in perspective. He is sympathetic to Halstead and the procedure he developed for breast cancer, the radical mastectomy, which has now been abandoned. He offers compelling evidence that much of the tragedy of Semmelweis—who failed to convince the medical world that puerperal fever could be prevented if medical students and doctors washed their hands—was of his own doing. If I have any reservation about Nuland’s choice of pioneers, it is



that places are not found for Robert Koch, as founder of bacteriology (but that may be a pathologist’s bias, whereas Nuland’s selection has a bias to surgeons), and Edward Jenner, founder of vaccination and immunology.

What links the doctors in these pages? More than anything else it is their self belief. All of the great

physicians and scientists have questioned accepted dogma and often been reviled but have nevertheless stuck to their beliefs and principles to prove their points. All had inquiring minds, even if this was not recognised. John Hunter, for instance, was considered a dullard in his youth—but was inquisitive enough to inquire, as a child, why “the leaves changed colour in autumn.”

Readers will learn not only much about the history of those who have changed our lives for the better but also nuggets such as Auenbrugger’s advice to writers (not to be ambitious of ornament in mode or style of writing but to be content if one were understood) and what Harvey Cushing learnt from Halstead (never do anything to a patient without understanding the why and wherefore). Sanjay Pai, consultant pathologist, Columbia Asia Referral Hospital, Bangalore, India sanjayapai@gmail.com

Cite this as: *BMJ* 2008;337:a922