Teach doctors economics, not management fads

Cam Donaldson, Angela Bate

No one will be gloating over the troubles of the car manufacturer Toyota with respect to its mass recalls because of faulty brake and accelerator pedals. The situation has caused great distress and potential serious harm among Toyota customers. Typically, there will be much schadenfreude over the efforts spent on trying to adapt the famous and much respected Toyota Production System (TPS) to the NHS and other healthcare organisations around the world (see BMJ 2008;337:a824, doi:10.1136/bmj.a824).

The principles of “lean thinking,” of which the TPS is but one exemplar, are not changed by Toyota’s woes. How can we argue against designing processes of care that eliminate waste and encourage standard working, saving valuable healthcare resources that can then be used to meet other needs? Nevertheless, the schadenfreude experienced by some may have an element of validity to it. As health economists, we admit to such feelings and want to explain our three main reasons.

Firstly, Toyota’s troubles challenge the impression that there is a magic bullet for greater efficiency in health care. Every few years another management fad comes along that everyone has to go along with but which denies the fundamental economic problem that faces the NHS—which is to recognise and manage scarcity of resources. Lean thinking and TPS give the impression that there is “pain-free money” to be had by eliminating waste and unnecessary variations in care. Of course, there may be some opportunities to generate such free money, but these are unlikely to meet the talked about forthcoming 20–30% clawbacks in NHS resources. The real problem is one of choice: about what to do and what not to do in terms of provision of care. Which groups of care providers or patients will lose out because benefits produced for costs incurred are not worthwhile relative to other uses of these resources? Such questions are about pain minimisation, and tackling them will not be pain free.

Secondly, if there is one opportunity for pain-free money arising from Toyota’s troubles, it is the savings that might now be had on cancelled trips to Japan and Seattle for NHS executives and senior doctors. Hundreds of thousands (maybe millions) of pounds have been spent on such jaunts. The beneficiaries might admire production line workers who spend hours thinking about how to save a millisecond in the process of hammering a rivet into a partially complete motor car, all taking place in a hierarchical culture that is very different from our own. Then they return as born again lean thinkers to tell health economists and other sensible people what they know already.

Thirdly, health economists in the United Kingdom and other countries have been banging on for years about the need to improve technical efficiency in health care and, indeed, how to do this by, for example, focusing on care pathways. Technical efficiency is merely economic jargon equivalent to lean thinking—providing the same services at less cost. The years of plenty, as witnessed by unprecedented increases in healthcare budgets and the ensuing culture of contentment in the NHS, has led to a generation of managers and clinicians not able to deal with the management of scarcity, of which lean thinking is only a part. Methods to deal with pain minimisation are also required.

Context is everything, and we need to think of ways to deal with this scarcity that fit with the culture and structures of the NHS. This requires thinking about incentives—for example, if patients are still admitted and a fixed tariff paid per admission, where is the incentive for commissioners to encourage leaner thinking in hospitals? If hospitals become leaner they might bank the spare cash for a rainy day and try to encourage use of the capacity that has been freed; but will commissioners be able to afford to pay full tariff prices for this?

Part of culture change requires thinking about education, not trips to Japan. Economics is the science of scarcity yet the NHS managers and doctors who manage scarcity on a day to day basis are not routinely taught economics. Quite simply, too, managers and doctors who understand scarcity and the principles of economics need to be given licence to get on with it without being diverted by the latest management gimmick. Development and implantation of tools to systematically manage scarcity of resources is now the most urgent problem facing the NHS. Denial of scarcity will result in the leanest possible NHS because without managers and clinicians able to manage scarcity there may not be an NHS at all. Cam Donaldson is Health Foundation chair in health economics, National Institute for Health Research senior investigator, Institute of Health and Society, Newcastle University, camdonaldson@newcastle.ac.uk Angela Bate is lecturer in health economics, Institute of Health and Society, Newcastle University.

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See EDITORIAL, p 605, FEATURE, p 622, ANALYSIS, p 628
Suicide watch
The museum of suicide in a new dark fairytale does little to deter visitors from taking their own lives, finds Margaret McCartney

Sewers, sex, and torture have spaces already devoted to their illumination, so why not give suicide a little more attention? Dan Rhodes’s novel has at its centre just such a place: a museum of suicide. It contains portraits of Vincent Van Gogh, sculptures of Antony and Cleopatra, models of train tracks and scale bridges, and a toy house with the walls “cut away so to reveal Sylvia Plath with her head in a gas oven.”

There is also a series of photographs of stars, including Halle Berry and Vanilla Ice, as a demonstration of happy endings—those who have failed attempts on their life. Room 10, called “Count your blessings,” invites people to write down something good about their lives and pin it to the wall (the owners of large sexual organs give particular vent for their gratitude.)

The benefactress of the museum is known as “Pavarotti’s wife” (having a husband whom she has steered firmly in the direction of appearing like Pavarotti). Her mission is “a prevention initiative, a way of dissuading people whose thoughts might be heading in the wrong direction.” She does not know how much she fails. The old man who unenthusiastically curates the museum has to replace the noose exhibit regularly, for the museum has become a favoured one-way destination, and the curator keeps this truth away from the benefactress.

She, though, has troubles of her own: “She had known the relentless nag of sadness, and there had been times when it had seemed it would never end, times when she had almost lost her strength of character, but she had always found within her the will to pick herself up and carry on.”

Her upbringing in Hamelin hardly helped: “There are those who find it impossible, who are unable to rid themselves of the image of them being so happy one minute, their little hands clapping, and their little tongues chatter, and so frightened and confused the next.”

This, combined with morbid fears for her own children, leads her to establish the museum of suicide as a way of “pulling them back from the brink.” Thus the establishment is born, and the characters surrounding it have their own interests in the contents.

Rhodes’s book has the soul of Voltaire’s Candide, but this is a dark humoured fairytale that requires an 18 certificate. Just as Candide bounded back from floggings, beatings, and his lover’s disembowelment, for “all is for the best in the best of all possible worlds,” so the population of Little Hands Clapping conspires to believe, most of the time, the best of all others. So, in this world, if one has been sexually abused for a long time, it’s a good idea to stay cheerful but also to accept that one is going to hell and hence join the Union of the Damned. The museum has its own very medical attendant, a general practitioner and widower who—oh yes—also has a penchant for human flesh. His first encounter with a fresh liver as a junior doctor gives him a taste for more and leads him to strike a deal with the old man to secure a permanent supply of meat for his several freezers. The story runs loops through several people’s bizarrely troubled lives and delivers the vile with zest.

But two things. Firstly, the book could be seen as a parable of what happens when people with kind enthusiasms, good intentions, but no evidence put their idea into practice. Having a museum about sewers is one thing; a museum about suicide is quite another. Did Pavarotti’s wife do a systematic review or consider the need for a randomised controlled trial of cities with suicide museums versus those without? I suspect not. And, of course, misaligning the body count, never mind the visitor numbers, puts the old man well within the spectre of misconduct already.

In seriousness, though, it is precisely this lack of evidence that has done so much harm to medicine, even when the intentions are good. I have patients who have told me that the posters of gaunt, haunted looking drug users designed to make them aware of the risks of drugs had the opposite effect. Here was a culture they wanted as their own. Current campaigns against obesity lack evidence that they will improve real life outcomes and, of course, cost time and effort. Are these useful interventions? And what about the harms—could they put people off contact with medical staff?

Candide, no doubt, would see that all was good in any case: but then again, he does, by the end of the novel, think that staying put in his life would be as good as having one’s body raped, hung, and dissected. So those inspired to erect a suicide museum to deter the act: think again.

And the second thing? The front cover contains a quotation from author Douglas Coupland that the book is “totally sick and brilliant.” This may be so, but it also means that you might not want to be seen giggling while reading it on the train.

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Murder she wrote

Literature, like the living world, can be divided into kingdoms, orders, families, genera, species, and even subspecies. For example, there is the kingdom prose; the order fiction; the family murder detection; the species the English golden age of detective stories; and the subspecies murders that take place in prep schools.

No doubt a Freudian might say that the very existence of such a subspecies is indicative of English attitudes to children or to education—or, of course, to both.

One detective story in which the murder takes place in a prep school is Murder at Half Term, first published in 1939, by Josephine Bell, the pen name of Dr Doris Bell Collier Ball (1897-1987), who married a doctor and practised with him in Greenwich until his death in 1936. Thereafter, for 45 years, she published a novel almost every year, writing her last one at the age of 85.

In 1953 Dr Ball was one of the founder members of the Crime Writers’ Association, which now has 450 members, or one per 133,000 head of population. There are no doubt some medical specialties with fewer practitioners in Britain than the CWA has members, and I have little doubt that if they went on strike they would soon bring the country to its knees.

Many of Josephine Bell’s books have medical settings, and there is hardly a better way to trace the changing mores of our profession, and of the country as a whole, over nearly a century than by reading her novels.

For example, her offering of 1976, Murder in Hunter Ward, tells a tale of union militancy in a general hospital’s private ward. The atmosphere is not so much pre-revolutionary as pre-anarchic; and the only reason that it does not seem as alien to me as the complacency of the pre-war middle class environment that she describes in her earlier novels is that I have no direct experience of the latter, not having been born.

Several of her novels have as their hero a medical sleuth, Dr David Wintringham, who takes time away from his research laboratory to uncover the murderers who seem to surround him wherever he goes. In Murder at Half Term a member of the cast of the school play is bashed over the head and subsequently dies.

It is Dr Wintringham, naturally, who provides the key to the mystery, when he realises that the actor did not die immediately after he was hit but recovered sufficiently to act his last scene of the play, before expiring of an extradural haematoma. (The book has a good description of Cheyne-Stokes breathing.)

I am not sure, however, that I will show the book to my wife (also a devotee of crime fiction). On the first page Mr Redesdale, the headmaster, is dressing for dinner and says to his wife: “I can’t possibly wear that tie. Haven’t I got another?” “I expect so. Have you looked?” Clearly he had not looked. He made a feeble gesture toward a drawer, but stood back as [his wife] interposed herself between him and the dressing-table.”

It goes without saying that the characters bear no relation to any real person, living or dead. Theodore Dalrymple is a writer and retired doctor

BETWEEN THE LINES

Theodore Dalrymple

Several of her novels have as their hero a medical sleuth, Dr David Wintringham, who takes time away from his research laboratory to uncover the murderers who seem to surround him wherever he goes.

By Richard von Krafft-Ebing Published 1886

Preceding Freud’s work in the area of sexuality by two decades, Richard von Krafft-Ebing’s study of deviant sexual behaviour was a colourful psychiatric text that was widely read in the European psychiatric community. Psychopathia Sexualis has been described as “a kind of schoolboy’s masturbatory compendium,” dealing as it does with behaviour such as fetishism, sadism, masochism, and exhibitionism. This content could mislead the observer into thinking that the book equated to little more than risqué literature for the masses. It is true that it attracted much attention in lay as well as medical circles, running to 12 editions. However, for the most part, it came from and was intended for European psychiatry’s academic core and needs to be considered in conjunction with contemporary 19th century trends.

Krafft-Ebing (1840-1902) was a German psychiatrist who acquired clinical experience in a number of different asylums. In 1874 he transferred to the academic world of Graz, Austria, and there made a name for himself after publishing large atlases of forensic psychiatry. Over the course of several decades he developed his ideas in the area of sexology, drawing heavily from the theories of the French psychiatrist Bénédict-Auguste Morel (1809-73). Morel had described at length the potential for the descent or “degeneration” of the human condition into madness and mental retardation. Psychiatric illness, he contended, could be directly inherited, and thus a mad individual bore the phenotypic characteristics of previous mad generations. While the ill effects for a family were all too apparent, so too, Morel argued, were there adverse outcomes for society. Those who felt drawn to ideas of sterilisation and euthanasia were considerably encouraged. In Psychopathia Sexualis Krafft-Ebing recorded a large number of psychosexual case histories. Included were examples of bestiality, incest, and nymphomania, and these he interpreted in the context of Morelian mental degeneracy. Thus an exhibited sexual behaviour could be both predicted and explained by the extent of insult to an individual’s family pedigree.

Some have criticised Psychopathia Sexualis for taking an overtly moralising stance and for contributing to the stringent repression of sexual deviancy in the 19th century. Furthermore it has been singled out as bolstering the move towards a rigidly biological approach to psychiatry. Such opinions probably go too far and take little account of the events of the period. I believe the book to reflect the widening sphere of human behaviour on which psychobiological theory cast its critical gaze. It demonstrates also the desire of psychiatry—an embryonic discipline at the time—to achieve a credible academic basis.

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Men behaving madly

When young, they get overexcited, climb trees, and fight. As adolescents, their earphones blare out thrash metal, and they grunt in response to any question. Testosterone makes them spotty, hairy, and moody, and sport becomes their only social expression. But feed and water them and they can, in a limited way, contribute to society. Their youth washes off and clogs the sink in their 20s, thanks again to testosterone. They start to go blind, unable to find their own clothes (usually because they have been tidied away), and seem to become deaf, as they stop listening. They don’t bother doctors, because they can’t be bothered, being too simple to be introspective or neurotic. In later life they become consumed by the sofa. But they can be amusing, loyal, punctual, and occasionally wise. Surprisingly many people love them dearly—for these are men.

A current disease awareness campaign aimed at men, called “Sorted in 10,” promotes “testosterone deficiency syndrome” (a rebranding of the unsuccessful “male menopause”). The campaign suggests that 42% of men with type 2 diabetes are affected, along with many of the general population of men aged over 40. Clearly the sponsoring company is showing a benevolent commitment to public service, but it should be noted that it markets testosterone replacement therapy costing £350 (€390; $530) a year. A “scientific” screening questionnaire called ADAM (androgen deficiency of ageing men) is used to aid diagnosis and carries a suggestion to take a printout to a local general practitioner.

But the truth is that there is no “manopause,” because testosterone concentrations decline gradually over time, without an acute cut-off point. And doubts remain over the measurement of testosterone, with wide daily variation within individuals and different men having different sensitivities to testosterone. Also, testosterone replacement therapy turns off endogenous production, causing testicular atrophy. Consider also that there are no long term, large cohort data on the safety of this therapy and persistent concerns about cardiovascular disease and prostate cancer.

The “validated” ADAM questionnaire is but quasi-science, just as biased and loaded as all other questionnaires. Even if you accept that the syndrome exists, recent research shows that the questionnaire has low specificity (European Urology 2007;52:1760-7), giving a high rate of false positives, undermining a man’s sense of wellbeing even further. So it seems that testosterone, rather like the male of the species, is more complex than it seems. Perhaps Mother Nature knows best, and we should reflect on the early claims of hormone replacement therapy in women and the later problems that it generated. There exists a fountain of youth that protects against the oestrogenic effect of obesity, improving muscle mass, energy, concentration, and endurance: exercise. Testosterone replacement therapy is just not wise.

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New images needed

If you search “medicine” on Google Images, you get a hundred million photographs. The most common image is a stethoscope. The next is a bottle of pills (or, sometimes, red and black capsules). The next is a surgeon, masked and gloved, slicing skin with a scalpel. Try “patient” and you will find lots of people in stripy pyjamas, lying obediently in bed, often with a spotty rash or a leg strung up in an orthopaedic hoist. Access a professional image site and you will get pictures of higher technical quality and cost—but the same outdated themes.

Nursing stereotypes are even worse. Excluding images of breast feeding (for which the US term is “nursing”), your hits will comprise little more than young, slim Anglo-Saxon women in starched uniforms, frilly hats, and black stockings. Outside the saucy websites they are usually either giving injections or doing thermometer rounds on Nightingale wards.

I once sorted through 10 000 images for one to illustrate a brochure for a masters course in primary health care. No hospitals, please, and something multidisciplinary, patient centred, and power neutral, if possible. I found one perfect picture—but that was three years ago, and I’m now looking for another. Her’s teeth.

Yet it is 13 years since Richard Smith wrote an editorial in this journal (BMJ 1997;314:1495) heralding the imminent demise of “industrial age medicine,” in which our hospital focused healthcare system made people into patients and infantilised, overinvestigated, and overtreated them. He predicted a new era of “information age health care” in which citizens—masters and mistresses of their own bodies and experts in their own illnesses—would use internet based sources to manage their chronic conditions themselves in the community, drawing eclectically and judiciously on the expertise in disease of nurses and doctors.

I have recently worked my way through half a dozen policy documents that were cleverly illustrated with pictures of accessible, flexible, patient centred clinicians (without white coats, stethoscopes, scalpels, or syringes). In the foreground were empowered patients managing themselves, usually of mixed ethnicity, with whom the clinicians were sharing decision making.

I want to know where the Department of Health gets these images. More fundamentally, has the revolution in roles and relationships in clinical care actually happened? If so, why has it so completely eluded the people who make a living from depicting our work visually?

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