



**Oliver Sacks**  
describes his own  
prosopagnosia in  
his latest book,  
p 110

## VIEWS & REVIEWS

# We should scrap targets for outpatient follow-up ratios

PERSONAL VIEW **Andrew Bamji**

**M**y interest in the issue of outpatient follow-up began when my hospital trust asked me to reduce my ratio of new to follow-up consultations to 1:2.1 in 2006. Attempts to discover why led me to a new performance indicator from the NHS Institute for Innovation and Improvement; it appeared on the website as an “NHS better care, better value indicator.”

I am a rheumatologist. I deal with inflammatory joint disease, which according to specialty guidelines (endorsed by the National Institute for Health and Clinical Excellence) requires short term follow-up to stability, with appointments a month apart, and then specialist follow-up at least once a year. From my follow-up database I calculated that to achieve the trust's target I would have to discharge half my patients. My trust managers said they were happy for me to do this because their GPs would have to re-refer them—and, by the by, said that I had no clinical responsibility for them. Re-referral would not only improve the ratio but also bring in extra money. (The Payment by Results tariff for a new patient consultation is £230 (€270; \$360), that for a follow-up consultation is £97, so you can calculate how much would be brought in by converting every third follow-up to a new consultation.) This was not foreseen by those who devised the indicator; patients who are discharged, in their financial calculations, stay discharged.

I don't want to run all my clinics in their usual state—heavily overbooked. I am getting older, and it's tiring. So I discharge every patient for whom it's clinically appropriate. But the reason there remain so many patients is that they need to be seen. They may be unwell and need treatment review; they may have acute flares (I run an instant access service for these patients); they may want a chat with someone who actually knows something about their disease (me).

I made an effort, abandoning half my patients with non-inflammatory disease—but as they were only 10% of my case load it made only a 5% difference. I wrote a document pointing out that GPs would not be keen to do regular reviews of patients who were taking disease modifying drugs or to manage my 200 or so patients taking biological agents. I discovered that our comparator trust had a completely different case mix; we saw twice as many patients with inflammatory joint disease and half as many patients with non-inflammatory



**Revolving door: patients are discharged and re-referred rather than followed up**

**What evidence is there that reducing follow-up appointments actually saves money and is better care as well as better value? In rheumatology there is none**

disease. The other trust put all referrals for back pain through rheumatology (they are “one-stop,” because they get referred on to physiotherapy), while we had a direct physiotherapy triage service. I suggested that we could redesignate all the back pain patients as rheumatology patients, which would fix the ratio target but would cost the primary care trust about £250 000 each year.

My trust politely listened to my arguments, understood (so I thought), and went away. Earlier this year I received a circular from a manager saying that the trust had agreed a ratio for 2010-11, of 1:1.88. This was signed off and non-negotiable. Other specialties received similar orders.

I protested to our managers in the light of institutional amnesia and the fact that we had had no input into any discussions and because research elsewhere that followed on from ours had confirmed that a “reasonable” ratio was between 1:4 and 1:7 for rheumatology (varying with case mix, number of doctors, and so on). I set out a long list of questions for my managers to ask the primary care trust to justify its demand, but they said that their hands had been tied, the deal was fixed, and we were not to see patients for whom we were not paid.

I then ran a “zero based” exercise to look at my new patients and calculate, according to our review guidelines, how many follow-up appointments should ensue. This pointed up quite considerable variations in referral pattern from surrounding areas but showed that for a service starting from scratch with my case mix the best you could achieve in year 1 was a ratio of 1:2.3 (based on my current practice) and that if NICE guidelines were followed to the letter the first year ratio would be 1:4.1. Assuming that, as time passes, the patients with inflammatory joint disease are reviewed less often as their disease becomes controlled—but remain under review at least annually as needed until death or relocation—and that the non-inflammatory patients are seen just once, or maybe with one review and then discharged, the numbers under review gradually rise, so the proportion of follow-up patients also rises. It is inevitable.

So, if these are the facts, what evidence is there that reducing follow-up appointments actually saves money and is better care as well as better value? In rheumatology there is none. The apparent savings are more than consumed by a higher spend on re-referrals. If you discharge rheumatoid arthritis patients willy-nilly to meet stupid targets you also lose any opportunity to do trials and to create patient groups and all the other benefits of resource concentration.

It saddens me that people are completing applications for clinical excellence awards that trumpet their success in meeting a ratio target. None of those who do it offer any clinical justification. Outpatient ratio targets make neither clinical nor financial sense. We should abandon them forthwith.

Andrew Bamji is consultant rheumatologist, Queen Mary's Hospital, Sidcup, Kent, and past president, British Society for Rheumatology [bamji@btinternet.com](mailto:bamji@btinternet.com)

Cite this as: *BMJ* 2011;342:c7373

[bmj.com/archive](http://bmj.com/archive)

● Personal View: Young, sick, and in need of support (*BMJ* 2011;342:c7450)

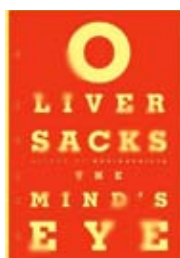
● Clinical Review: Management of rheumatoid arthritis (*BMJ* 2010;341:c6942)

See **CLINICAL REVIEW**, p 95, and **PRACTICE**, p 104

REVIEW

# Strange cases of twisted vision

Oliver Sacks's latest book gives us further anecdotes about the peculiar world of the brain, and this time one is about him. **Fred Charatan** is awed by patients' tenacity in these cases of visual disturbance



## The Mind's Eye

A book by Oliver Sacks

Alfred A Knopf, pp 263,

\$26.95

ISBN 978-0307272089

Rating: ★★★★★

The concert pianist Lilian Kallir used to be an accomplished sight reader and could easily play a Mozart concerto by sight, but she first lost that ability during a concert in 1991. "Alexia sine agraphia is not that uncommon . . . but Lilian was the first person I had encountered whose alexia manifested first with musical notation, a musical alexia," writes Oliver Sacks, professor of neurology and psychiatry at Columbia University, in his latest book.

Sacks has seen thousands of patients in the past decades, working as a general neurologist mostly in homes for elderly people. "All of them have taught me something, and I enjoy seeing them—in some cases, we have been seeing each other for twenty years or more." In *The Mind's Eye* Sacks describes the cases of patients who have lost an ability related to visual communication, such as aphasia (loss of the ability to write or recognise words), agnosia (to recognise objects or people), alexia (to read), agraphia (to write), prosopagnosia (to recognise faces), and astereoscopy (to see stereoscopically).

Sacks visited Kallir at her Manhattan home and eventually diagnosed posterior cortical atrophy, first formally described by Frank Benson in 1988. Such patients may progress to develop Gerstmann's syndrome—left-right disorientation, difficulty in writing and calculation, and finger agnosia—but Kallir did not.

Visiting her several months later, Sacks was keen to see how she coped with shopping and the challenge of a busy New York neighbourhood. She had emphasised to him that colour was her most immediately visible cue for recognising people. So, fearing that they might be separated, Sacks dressed entirely in red for the visit. In her case the disease was relatively benign: years after the first symptoms she did not get lost in her own home or neighbourhood.

In her music Kallir not only coped with the disease "but transcended it," Sacks writes. By mentally arranging it overnight she was able to play a Haydn quartet. Her ability to read music would come and go. "Thus it was more important than ever for Lilian to 'code' things, to provide easily used sensory cues—above all, color, to which she remained intensely sensitive."

Sacks himself developed prosopagnosia, and in his essay "Face blind" he explains that people with a severe form may be unable to recognise their own spouse or child. Sacks empathises with fellow patients: "A number of patients with prosopagnosia have come to autopsy. Here the data are clear: virtually all patients who acquire prosopagnosia, irrespective of the cause, have lesions in the right visual association cortex, in particular on the underside of the occipitotemporal cortex; there is nearly always damage in a structure called the fusiform gyrus."

Since the 1980s, when it became possible to use computed tomography and magnetic resonance imaging to visualise the brains of living patients, lesions in what came to be called the "fusiform face area" have been identified in patients with prosopagnosia. Sacks's penultimate essay is a personal journal from 2005 to 2009, describing his discovery

of a melanoma in his right retina close to the optic nerve. He underwent radiotherapy and laser treatment and endured substantial loss of vision. This interfered with the completion of his book *Musicophilia* (*BMJ* 2008;336:1133).

In another case Howard Engel, the Canadian writer known for his Benny Cooperman series of detective novels, woke one morning unable to read the newspaper and thought that he may have had a stroke. Tests in Toronto's Mount Sinai Hospital confirmed that he had indeed had a stroke, affecting the left occipital cortex. Although he could still write, like Lilian Kallir he had alexia sine agraphia. Much of the rest of the essay describes how Engel dealt with the desperate daily struggle of someone with alexia. "His whole life and identity (to say nothing of his livelihood) depended on his ability to read and write." A therapist suggested that he keep a book to record his thoughts. Within a few weeks he had produced a first draft of a new novel called *Memory Book*, which was published in 2005. "The problems never went away," Engel writes, "but I became cleverer at solving them."

"In the past few decades neuroscience has confirmed that the brain has more powers of repair and regeneration than was once believed," Sacks writes. "There is far more 'plasticity,' too, a greater capacity for undamaged brain areas to take over some of the functions of damaged ones, providing the damage is not too extensive."

Besides his own graphically described fears and pains, Professor Sacks's hallmark is his crystalline prose, which is a pleasure to read. "I could not help thinking of that other day, the day everything started to go wrong, at the end of 2005—and of the nearly four-year fight in which the eye carried on, with ever more of the retina being nibbled at or blasted away. Was this the final knock-out blow?" He describes "a biggish slice of the periphery to my right, forty degrees or more, like a very large slice of cake, has been carved out of my vision. I see, roughly speaking, nothing to the right side of my nose." Sacks remains tortured by this loss of space on his right side.

Fred Charatan is a retired psychiatrist, Boynton Beach, Florida [charatanf@thecascades.us](mailto:charatanf@thecascades.us)

Cite this as: *BMJ* 2011;342:c7110 [bmj.com/archive](http://bmj.com/archive)

Review: Wake up and dance (*BMJ* 2010;341:c6709)

Medical Classic: Awakenings (*BMJ* 2007;334:1169)

**Sacks developed prosopagnosia, and he explains that people with a severe form may be unable to recognise their own spouse or child**





BETWEEN THE LINES Theodore Dalrymple

# Perfect prognoses

Prognosis is, as we all know, an inexact science, at best. Some people live longer than predicted, and some do not survive as long. It is even possible that there have been doctors who, in the secret recesses of their heart, have felt slightly irritated that their patients have defied their crystal clear instructions as to how long to live.

But how accurate would we like prognosis to be? Would any of us like to know in advance the exact time and date of our own death or those of the people around us?

Is all knowledge necessarily good? I once discussed our understanding of the brain with an eminent professor who thought that it was. He was all for maximally increased understanding, whereupon I described a patient of mine who believed that his neighbours had developed an electronic scanner that could read his thoughts at a distance. If such a thing were possible, would it be desirable? I thought not; on the contrary, it would be hell on earth. Only secrecy makes life tolerable.

**If a man is apprised of his time of death he might very well die at that time as a self fulfilling prophecy, for psychological reasons**

The science fiction writer Robert A Heinlein (1907-88) wrote a story about perfect prognosis, called "Life-Line," first published in 1939. In the story a maverick researcher called Pinero, of indeterminate scientific discipline and the provenance of whose doctorate is questioned by orthodox scientists who don't want to believe him, has developed a machine that is able to predict with great accuracy the time and date of any person's death.

At a meeting of the Academy of Science Dr Pinero is insulted and shouted down. A doctor in the audience objects that if a man is apprised of his time of death he might very well die at that time as a self fulfilling prophecy, for psychological reasons, "whether the distinguished speaker's mechanical egg-timer works or not."

Dr Pinero suggests an experiment to overcome this objection. Life insurance companies try to obtain an injunction against the experiment, because if Pinero's device worked it would completely destroy the need for or indeed possibility of life insurance. Dr Pinero replies that he



Robert A Heinlein: predictions of time of death

is only doing retail what the actuaries of life insurance companies do wholesale.

He, or rather his machine, correctly predicts the time of his death, very near in the future: he is murdered at the behest of the chief of a life insurance company, and his machine, whose secret he has not divulged, is smashed beyond repair by vandals in the pay of the company.

For myself I side with the vandals, having always had a secret sympathy with the Luddites. A fortune teller at a funfair once predicted when I was 16 that I should live to be 84, and since her only other two predictions (that I should be a doctor and travel extensively) have come to pass I cannot help but wonder whether I shall spend the 84th year of my age in a state of anxiety, notwithstanding the scientific absurdity of her proceedings. Fortunately she kept her predictions to three because I paid her only half a crown instead of five shillings. For the higher sum I probably would have learnt the nature of my last illness and would have been turned into a hypochondriacal wreck.

Heinlein made many prescient predictions or guesses. Among the least happy, written in 1949, is: "There are still more outhouse than flush toilets in the United States, the land of inside plumbing. And the ratio will not have changed very much on the day when men first walk the silent face of the Moon."

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2011;342:c7467

## MEDICAL CLASSICS

### Mother, Madonna, Whore: The Idealisation and Denigration of Motherhood

A book by Estela V Welldon

First published 1988

It is a truth universally acknowledged that women, being in want of a penis, lack the necessary means for perversion. Or so it was until the publication in 1988 of *Mother, Madonna, Whore*. This seminal work by Estela Welldon was based on her experience of working as a consultant forensic psychotherapist at the Portman Clinic in London.

She challenged the accepted wisdom that women did not suffer from perversions. Her original ideas sent shockwaves through the psychoanalytic community and the feminist theorist circles of the time, who claimed that women were always victims, powerless in the face of sexual abuse from men.

Welldon showed that women do indeed suffer from perversions and that for many seeking help their situation is rendered more isolating because the medical profession refuses to acknowledge their suffering and is ignorant of female psychopathology. Welldon's work educates and enlightens us. *Mother, Madonna, Whore* contains many clinical vignettes that demonstrate perverse mothering and the transgenerational pattern that this follows. Women, who traditionally lack power in the male dominated world, exert huge power over their helpless infants and children, who are perceived as an extension of their bodies and their selves.

Perversion in women is directed against the self, often taking the form of self injury, eating disorders, and self starvation or repeated assaults in the form of cosmetic surgery. It may also be directed at their children; women who have been abused may in turn become abusers.

Motherhood is demanding and often lonely. Physical neglect and abuse, sexual abuse, fabricated or induced illness—such are the manifestations of female perversion towards children. If a woman has not herself enjoyed the benefits of good mothering she may carry on the pattern of neglect and abuse, which will continue from generation to generation.

When this book was published it was the subject of many column inches in the general press; but, 20 years on, the outcry and disbelief

that the nursery worker Vanessa George could abuse small children in her charge in the 2009 Plymouth child abuse case showed that Welldon's message has not been widely understood. Sadly the medical profession may also need to be reminded of women's capacity for perverse behaviour and the difficulties of motherhood.

*Mother, Madonna, Whore* is an important and classic contribution to a painful and contentious subject—one that doctors shouldn't ignore.

Pamela Ashurst, retired consultant medical psychotherapist, Southampton [pmashurst@doctors.org.uk](mailto:pmashurst@doctors.org.uk)

Cite this as: *BMJ* 2011;342:c7155

[bmj.com/archive](http://bmj.com/archive)

● Review: Written on the body (*BMJ* 2010;341:c6122)

● Medical Classics: Two reports on the Cleveland case (*BMJ* 2010;341:c6262)



# When marketing masquerades as education

FROM THE  
FRONTLINE  
Des Spence



The fire alarm at our health centre is tested regularly. Shortly after one such test a forwarded email flyer from a Westminster Health Forum seminar on chronic obstructive pulmonary disease appeared in my inbox. This is a high level seminar, with representatives from the Department of Health and a collection of baronesses, lords, professors, and members of parliament—not the sort of people I normally meet in my 1970s concrete dugout. A transcript of this “CPD [continuing professional development] certified” seminar is to be circulated to “ministers and officials at the department of health.”

The tone of the seminar is of informed impartiality, but this meeting is “supported by” AstraZeneca, which has a speaker on the programme, and there are representatives from GlaxoSmithKline and MSD. Is this a good idea? Obviously the industry has a legitimate right to lobby the government, and I suspect that these rights are exercised frequently. But I question the role of a pharma educational event providing transcripts to the Department of Health.

I emailed a request on the level of “support” given but had no response. This might all seem like paranoia. But the fact that AstraZeneca and GlaxoSmithKline’s combined global sales in the respiratory market are \$10bn might be deemed a vested interest enough. However, it is more than this. The programme uses emotive language such as finding the “missing millions” of patients, talks of chronic obstructive pulmonary disease (COPD) in “younger people,” and uses

the terror tactic of “increasing incidence.” The impression is of underdiagnosis and undertreatment. The result will be pressure to educate (presumably the role of the great medical unwashed, general practitioners), and increasing diagnosis and ultimately prescribing.

But smoking and the COPD death rate are falling. Also, there is no evidence that screening works for mild disease, and the current research base is older patients with substantial symptomatic disease. The definition of early disease is flawed, lacking clinical robustness. This is leading to overdiagnosis, driven by well intentioned but foolish missionary medicine and the calculated pursuit of profit by big pharma. The result: millions of patients medicalised and stigmatised with chronic life threatening illness, limiting their employment and expectations.

Such high level educational marketing activity has also promoted osteoporosis, cholesterol control, and diabetes, disfiguring and distorting healthcare. More medicine is not better medicine, and this is the theft of wellness. In the real concrete world the solution to COPD is obvious: better tobacco control and more physical activity. The influence of special interest groups, lobbyists, and big business in national health policy should be limited but at the very least should be open and transparent. This meeting should set alarm bells ringing.

Des Spence is a general practitioner, Glasgow [destwo@yahoo.co.uk](mailto:destwo@yahoo.co.uk)  
Cite this as: *BMJ* 2011;342:c7469

# My personal mountain

THE BIGGER PICTURE  
Mary E Black



I have finally submitted my doctoral thesis, a mixed methods case study of the first household survey of children and women in Bosnia-Herzegovina since the conflict.

The naive idea that this was merely a spare time project led me a tortuous dance through the bowels of analytical frameworks and the deep dark nights of numbers that never add up, my path dimly lit by the wisdom of an adviser who has seen it all before. I have drunk deeply from the cup of creative prevarication, been humbled by the simplest obstacles, and flip flopped through wildly contradictory advice from colleagues and friends. The final days were sleepless battles with erratic tables and referencing software that ran amok. The final thesis was both more and much less than I expected.

Taking a large and expensive piece of work and examining it anew, using the benefits of hindsight and a structured methodology, was

revealing. International development practitioners are constrained by the need to implement projects on target and on time and to ensure that funds are spent appropriately. Sometimes our work is evaluated, and a team of strangers will come in and see whether we have met our objectives. Rarely is there time or opportunity to reflect more widely beyond the immediate task in hand. Academics, who dance to another tune, may lament the lax methodology applied to much development work and the obfuscation used when reporting to donors. My small contribution examined the interface between these two approaches. I wish these paths could cross more often, because academics and practitioners often fail to understand each other.

There is a logic to the arcane doctoral process. You must submit to the constraints of the form and labour up its slippery slopes. In common with

all mountains, when you arrive at the summit all that can be seen are more peaks ahead; the conquered path lies out of sight, covered by mist. In the days since I pressed “send” I have paused to rest, taking deep breaths of fresh air while admiring the vista ahead. It was rather nice to be closeted away, deferring mundane tasks. I do think at some time I may retire to a nunnery to contemplate higher pursuits full time.

I am sitting in a small cafe on the harbour front in the island town of Hvar in Croatia on the last day of 2010 with one of the world’s top sailing coaches. “I did a great thing last week and finally submitted my MD thesis,” I announce. He gazes intently at the winds fanning out across the bay. Puncturing my smug self importance he asks, “What’s an MD?”

Mary E Black is a public health physician, Belgrade, Serbia [drmaryblack@gmail.com](mailto:drmaryblack@gmail.com)  
Cite this as: *BMJ* 2011;342:c7472