**"The pursuit of profit is the scourge of US healthcare. Crude activity and turnover is rewarded, not quality"**
**Des Spence, p 57**

PERSONAL VIEW **Mohammed Shafiq Ibrahim**

# A revolution in an Egyptian hospital

Millions of Egyptians participated in the revolution, but only the doctors and nurses took part as professionals. We treated the injured in so called field hospitals created by the protesters in Tahrir Square and in public hospitals. We took this experience back to our hospitals after Mubarak fell in February 2011 and started the fight to improve our health service and to raise state health spending from 3.5% of the budget to 10% (the Egyptian government pledged 15% in the 2001 Abuja Declaration).

We achieved amazing things during these campaigns at the hospital where I work as a neuropsychiatrist. Manshiet el Bakry is a state funded general hospital with 90 beds, serving 1000 outpatients daily in Heliopolis.

At first it was hard to convince all hospital staff that they needed to join an independent union to defend their interests. A petition campaign was started to support doctors' demands after Mubarak's fall. Nurses and other staff wanted to sign. Initially the doctors refused, but other staff insisted. Discussions began about the demands and needs of all staff and about working together in a new union. The independent union grew, culminating in a massive celebration in Cairo, in the building of the journalists' union, which had supervised our free and fair union elections.

Through the nascent union we held a free democratic election for the posts of hospital directors. The winning candidate was a doctor with management experience; the others a young female junior doctor and a senior doctor. We successfully pressured the chief of Cairo's health authority to appoint the winner as official director by threatening strikes.

**Better relationships with patients have resulted from the staff feeling that we share ownership of the hospital and the power to change and improve things**

Our greatest achievement at Manshiet el Bakry hospital, however, is how our union has broken down social, cultural, and class barriers, creating equality between staff. Our success lies in asserting everyone's equal right to express opinions, whether they are doctors, nurses, manual workers, technicians, departmental heads, or permanent or fixed term employees. We insist on democratic principles, respect for the majority view, and the best interests of hospital and staff in patient care.

Breaking down these barriers has been the biggest factor in improving health services for patients. Staff have begun to feel that it is our hospital, and we are in charge. Colleagues spend time outside working hours in the hospital, and doctors, nurses, technicians, and manual workers are talking to each other. We learn from each other and from searching for solutions to our common problems.

We face great problems, from broken lifts and dirty water tanks to acute shortage of medical supplies, but we are solving many quickly through group discussion and working together, both formally and informally.

Our clinical performance has improved through better doctor/nurse relationships, particularly tackling the nurses' need to be treated with respect and appreciation by doctors. These psychological factors have been key to creating a shared commitment to work despite the acute problem of low pay. Nurses earn up to 300 Egyptian pounds (EGP) (£32; €38; $50) monthly; only EGP1 for a 24 hour shift. These wages don't cover basic needs: a kilo of meat costs EGP50, and monthly rent on a small slum area flat is EGP350.

Better relationships with patients have resulted from the staff feeling that we share ownership of the hospital and that we have the power to change and improve things. Manshiet el Bakry is one of the few hospitals that hasn't suffered from security problems and attacks by patients' relatives. Our accident and emergency reception has stayed open at times when other major hospitals have had to close their doors.

In the hospital we implemented the slogans of the 25 January revolution: changing the old regime, achieving freedom of opinion and social justice for all. We want to see this in every Egyptian institution: a vision of a revolutionary Egyptian society, organised and united against the corrupt, hateful people in charge for too long. When I asked one of our cleaners for her thoughts about the union, she said what we regularly say to management: "Give us the rights we have worked for." But in union meetings I add, "If they don't give us our rights, we have to take them."

Our experiment is spreading. Seven other hospitals have formed independent unions. We are working to expand and unite our unions. However there is a backlash, with fierce attacks from the ministry of health and supporters, sitting in their air conditioned offices. Since July, management and even our elected director have reduced formal participation of staff in discussions, although union representatives still meet management daily. Staff, many surprised at the backlash, are making links with the revolutionary experiments across Egypt and questioning the role of management in general. We have shown that together in the union we can improve things for patients and staff and are considering how to strengthen our influence on the future shape and spending of our public health services.

**Healthcare workers played a key role in last year's uprising in Egypt**

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REVIEW OF THE WEEK

# Stop the medicalisation of old age

The "egregious marketing" of therapies for everyday ailments in older people, along with disease mongering and overtreatment, help no one. But which interventions lack proved benefit? **Graham Mulley** found answers in this iconoclastic book

**Rethinking Aging: Growing Old and Living Well in an Over Treated Society**

A book by Nortin M Hadler

University of North Carolina Press; 250 pages; £25

ISBN 978-0807835067

Rating: ★★★☆

How are we to ensure a long life and a healthy old age? It helps to have aged first degree relatives (genetics contribute to about 25% of lifespan). Much depends on where you live—which part of the city (Kensington or the east end of London), which town (people in Okinawa in Japan, Nicoya in Puerto Rico, Loma Linda in California, and Sardinia have the greatest longevity), and which country (you are likely to live longer in Japan or San Marino (an average 83 years) than in Malawi (47 years)).

Longevity is influenced by educational level, financial status, social engagement, having a job (and one you enjoy), skin colour, religiosity, and attitudes to life. It is wise to be prudent about weight, diet, and alcohol; to take regular exercise; and to avoid smoking.

Yet the explanation for the unprecedented increase in the numbers of very old people is not entirely clear. The early gains were attributed to clean water, better sewage disposal, improved nutrition and housing, as well as advances in maternal and child care. More recent extensions to lifespan have partly resulted from medical advances. Strong evidence shows that elderly people benefit greatly from a comprehensive assessment by a skilled and dedicated team and judicious and appropriate treatments. It is unacceptable not to give sick old people the best of modern medical technology. Medical ageism, which used to mean denying people appropriate investigations and treatments simply because they were old, however, now includes overinvestigation and subjecting frail elders to unpleasant, unnecessary, and unproved procedures and therapies.

Few doctors entered medicine to become biological accountants. Yet the economics of healthcare of old people are now of vital concern. The combination of the apparently insatiable demand for treatment; the greying of many nations; and the present parlous state of many nations' economies present a scary challenge to politicians, managers, and health professionals. How can we afford to give optimum care to the burgeoning number of elders?

In Nortin M Hadler's iconoclastic book we find possible solutions. Firstly, by persuading people in their last years (and their relatives) not to insist that everything possible is done in a futile attempt to postpone death. Secondly, by not doing procedures or prescribing drugs that are ineffective or potentially harmful, costly, and which have little or no evidence base.

**Medical ageism . . . now includes overinvestigation and subjecting frail elders to unpleasant, unnecessary, and unproved procedures and therapies**

The author offers many examples. He is withering about many screening activities: mammography yields trivial gains; there is no need to measure bone mineral density in well women; a single flexible sigmoidoscopy at 60 is sensible—but not repeated for 5-10 years—if at all. Many drugs are a waste of money: micronutrients, calcium and vitamin D, for healthy elders; antioxidants; most drugs to strengthen bone; and glucosamine for osteoarthritis. His scepticism

about oral hypoglycaemic agents and adding a second hypotensive drug will surprise many clinicians.

He informs us that there is little effective treatment for most metastatic cancers. He is fierce in his criticisms of interventional cardiologists, saying that coronary artery bypass surgery does not work. There are no randomised controlled trials of vertebroplasty or for operations for spinal stenosis. Surgery for myelopathy and radiculopathy is of uncertain value. Shoulder injections should be relegated to the dustbin of history; therapeutic ultrasound and joint lavage are a waste of time. I found that many of his assertions were confirmed in Cochrane reviews.

The author has a felicitous way with words. Algorithms are road maps. Spondylosis is a fancy name for age related changes in the bones of the spine. Colonic polyps are like grapes on a stalk, the gut's equivalent of the prostatic nodules of benign prostatic hypertrophy. I share his dislike of contemporary management speak in the new world where doctors are providers and patients are users of care. He avoids understatement in his condemnation of those specialists who in his view practise unpleasant and unproved technique and of the US system of healthcare, aspects of which are morally bankrupt.

The book is not intended to be a geriatric textbook, though it gives much medical detail of many important conditions and has more than 400 references. Neither is it a self help guide for lay people. Key topics such as sexual problems, deafness, and skin care are missing; incontinence gets only half a page, and delirium receives a brief mention. Yet this is much more than a diatribe: there is a poem by Keats and mention is made of Kant, Maupassant, and Shaw.

Hadler's main aims are to make people aware of the limitations in the evidence base of many medical procedures and to encourage them to ask their physicians to explain the risks and benefits of interventions. Though his use of aphorisms and hyperbole sometimes weakens his case, his questioning of many conventional practices is refreshing and important. His central tenet is that many clinical outcomes will be unaffected (and sometimes improved) by doing much less. In pleading for caution and clinical wisdom, he also offers a partial solution to the huge problem of how we might afford to provide good medical care for old people.

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BETWEEN THE LINES **Theodore Dalrymple**

# Cholera in couplets

Sanitation and sanitary precautions might not seem a very promising subject for poetry, but in 1871 a sanitary worker called Alfred Power published a small pamphlet of verses called *Sanitary Rhymes*, containing *Personal Precautions against Cholera and All Kinds of Fever*. It cost sixpence and was not to be sold in quantities of fewer than five because it was intended for the use of the masses. It was dedicated to Edwin Chadwick, "the founder of sanitary legislation."

As perhaps is only to be expected, it is not great poetry—in fact it is doggerel, but it contains lines that are, in their own way, memorable.

The first verse is devoted to the skin: "The outside skin is a marvellous plan / For exuding the dregs of the flesh of man . . . / It is the outward gauge of health: / When it goes well with the outside skin / You may feel pretty sure all right's within . . ."

Because the author has only a loose grasp of the causes of disease, his advice to readers is muddled and incoherent but not therefore without good sense. Excessive drinking, overcrowding, and dirty water are all to be avoided.

"Should the Cholera light on a temperate man, / Cordials, opiates and stimulants do what they can . . ." It is quite otherwise with the drunkard: "On the Drunkard, alas! from habitual use, / These agents so slight an impression produce, / To relieve his prostration and pain they want power, / He is flung on his back and is dead in an hour."

Overcrowding acts because of the deadliness of carbon dioxide (the fear of which has a faint echo in the night time removal of flowers by hospital beds):

"When people stay long pent up close in a room, / Replacing what Oxygen Gas they consume / With Carbonic, the Blood, which requires to be fed / With Oxygen, gets the Carbonic instead./ Hence alas! comes the Typhus, our deadliest pest, / That steals on its prey while securely at rest; / Hence, chiefly, Consumption, that scourge of the Lung, / Which so often the human nest robs of its young."

**"Your water, transparent and pure as you think it, / Had better be filter'd and boil'd ere you drink it"**


**Punch satirised Chadwick's legislation**

Dirty water is another foe of human health, but the dirt is all the more dangerous because not always apparent to the senses:

"The goodness of Water depends on its source; / When pure it is bright and transparent of course: / But is purity cannot be judg'd by the sight— / Though impure, it might still be transparent and bright. / When trickling through Earth-pores it enters your well, / What it keeps in solution no mortal can tell / Without chemical tests; for if sewage be there, / It will scarce give the nose any taint through the air."

The advice, then, is as follows: "Your water, transparent and pure as you think it, / Had better be filter'd and boil'd ere you drink it."

Despite this, the author did not fully apprehend germ theory of disease. He also blamed unripe fruit for cholera. In his notes to his poems, the author advises the cholera sufferer that: "Happy the patient who has a home in which he can be effectually treated without removal to hospital; for the known excess of hospital mortality from cholera, beyond the rate in cases treated elsewhere, is mainly caused by the debilitating effects of the process of removal."

Asking students to dissect the errors of the past might be a good way of teaching epidemiology and medical logic.

Theodore Dalrymple is writer and retired doctor

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# MEDICAL CLASSICS

**The Primal Scream**

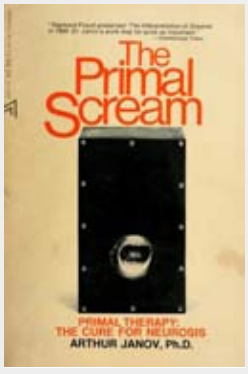
A book by Arthur Janov

First published 1970

So called primal therapy was pioneered by Dr Arthur Janov in the late 1960s. He describes it as a natural therapy based on his hypothesis that most psychological disturbances are disorders of feeling that can be traced back to the traumas of conception and childbirth.

Janov's belief challenged and contradicted classical Freudian and neo-Freudian schools of thought, which suggested that we are born neurotic and with a healthy set of defence mechanisms that enable us to function well in society. However, primal therapy is based on the assumption that we are born of nothing else but ourselves and that these defence mechanisms in a sense hide our true self, with our desires and wishes repressed. These defences, Janov argues, are built around primary care givers—our parents—who themselves have unhealthy defences that restrict their lives.

Through a series of fascinating although hard to believe studies, Janov shows how primal therapy can take people back to the origins of their neuroses. His particular brand of regressive therapy has initially reticent people exploring early childhood experiences. They have maintained a restricted life, sometimes in unsuitable marriages and employment. Eventually, after months of therapy, screaming out their repressed memories, the healing process starts as they discover their so called truer selves. Sometimes his patients do not seem to function any better in their newly discovered lives, with some divorcing their spouses and others giving up their jobs. However, Janov believes that they are more free as individuals.




Other parts of the book are much harder to reconcile with modern thinking or my own beliefs. The chapter on sexuality and homosexuality, for example, where Janov suggests that homosexual people are by their nature neurotic because a "truly sexual person is heterosexual." He explains this in terms of enduring abuse or not having the right type of love during a child's formative years.

Janov continues to practise as a psychotherapist in the Primal Center in Santa Monica, California. He has undoubtedly contributed to our knowledge of the origins of anxiety and anxiety related disorders; however, as a psychiatrist and cognitive analytical therapist I am not convinced by his approach, and it needs to be considered in its cultural and historical context.

Janov was one of the first therapists after Freud to challenge conventional Freudian and psychotherapeutic notions of unconscious defences as being essentially healthy mechanisms, instead viewing them as unhealthy or even damaging, and he qualified his reasons through the cases he treated. *The Primal Scream* is an important read for any doctor interested in psychiatry.

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FROM THE FRONTLINE **Des Spence**

# Lessons from America: primary care

If you think NHS reforms are complex, try looking at the organisation of healthcare in the United States. Contrary to our perceptions, the US government does care about its poor, young, and old. Through programs like Medicare and Medicaid the government is, in fact, the biggest provider of healthcare in the US. For those not covered by the state, there are a vast array of medical insurers and plans. But despite free market "competition," insurance remains unaffordable to many middle income families. These companies have dividends to pay, and this leaves 50 million US residents without adequate health cover.

The primary care structure is also impossibly confusing. There are "family doctors," "medical internists," and "general practitioners." All seem to have different and conflicting responsibilities and training. Some are purely private but many see a mix of public and private patients. There is a range of nurse practitioners and physician assistants who seem to work largely independently. Appointment times vary—some doctors see 30 patients a day in government "Medicaid mills" but others in private practice may have half hour appointments. Lax gatekeeping means patients can directly refer themselves to a specialist. Open access and limited information sharing mean that "doctor shopping" for the latest advertised medication or unnecessary investigation is common. In most systems, payments are based on "fee for service." This necessitates billing—a wasteful bureaucratic process that consumes 20% of all health costs (*Health Affairs* 2005;24:1629-39). That Wal-Mart now offer primary care walk in services shows that medical care is seen as a profitable service industry (http://on.wsj.com/tb6X4l).

**It is absolutely clear that the pursuit of profit is the scourge of US healthcare. Crude activity and turnover is rewarded, not quality**

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Thanks to relatively poor pay and low status, the US struggles to recruit general practitioners (*BMJ* 2011;342:d2684). Earning potential is important to US doctors, who leave university with average debts of $158 000 (£100 900; €119 800).

US residents are acutely aware of their chaotic health system—every new administration attempts reform. But it is absolutely clear that the pursuit of profit is the scourge of US healthcare. Crude activity and turnover is rewarded, not quality. The powerful vested financial interests of doctors, insurance companies, and big pharma collude, through political lobbying, to prevent fundamental reform. Primary care in the US is complicated, fractionated, inefficient, and fuels medical consumerism, overdiagnosis, and overtreatment. Contrast it with the UK, where primary care is simple, efficient, fully integrated, incentivised towards non-intervention, regulated, standardised, and high status. The argument against the NHS reforms and the introduction of profit is simple—economics, economics, economics.

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I thank Robert Kennedy, Chris Smith, and Allen Perkins
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STARTING OUT **Kinesh Patel**

# Are we prepared to sacrifice good feeling for pensions?

Having two identities is always difficult—and it's usually a bad idea. Just ask the Liberal Democrats how difficult it is to be faithful to their two different masters—their ideology and the Tories. At least for them it will all be over in three years.

Some of their discomfort must result from the government's attack on public sector pensions. The press has widely described the cost of senior doctors' pensions as unaffordable, and this has led to doctors' exposure to a new dose of vitriol (*BMJ* 2012;344:e613).

In time honoured fashion the BMA has stepped in to defend pensions. But, and this is the difficult question, which master does the BMA really serve? I remember asking a former BMA president which interests took precedence: those of the NHS or those of doctors. Surely the fundamental role of a trade union is to look after the interests of its members?

The truth is, however, that the NHS would be better off not having to pay such big pensions. Yes, sure, a few doctors would retire disgruntled. But most would soldier on, a little embittered, aware of their inability to effect any change and of the lack of a prospect of better employment elsewhere.

Our problem is that we want to be liked and at the same time reap the benefits of a good pay packet and pension; we want to have our cake and eat it. Unfortunately, the era of plenty has come starkly to an end, and decision time is looming.

It is a simple choice: we can either give up our popularity and fight for our interests—the unpalatable but rather productive Bob Crow school of thought—or we can largely acquiesce, accept some token concessions from the government, and retain the public's good feeling towards us. That good feeling, however, is undoubtedly weaker than it used to be. Even during my short career I see the difference. Patients used to say to me, "You should be paid more." Now no one in the general population thinks or says that.

**Patients used to say to me, "You should be paid more." Now no one in the general population thinks or says that**

We need to decide as a profession how we wish to continue. If it's a battle we want, it will take more solidarity than we have been accustomed to. But the results may be worthwhile: it's no accident that a London Underground train driver will earn a salary of £52 000 (€62 000; $82 000) a year in 2015, more than the basic salary of a final year registrar. The real question, I suppose, is the price for more money worth paying?

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