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## When managers rule

Patients may suffer, and they're the ones who matter

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Written by the managing director of Sainsbury's supermarkets, and three other businessmen, the "Griffiths report" (1983)<sup>1</sup> unleashed a management revolution in the NHS. The report's key recommendations were for a supervisory board to overview policy and strategy and a management board to implement it, together with regional, district, and unit general managers. Twenty five years later, the *Health Service Journal* ranked Roy Griffiths 12th in its list of the 60 most influential people in the NHS's history for his role in setting NHS management on its current path.

After the report's publication, the administrator of our district management team said something like "we will run the show from now on." This was despite Griffiths' recommendation that, consistent with clinical freedom for clinical practice, clinicians should be involved more closely in management and participate fully in spending decisions.

At the time, Manfred Davidmann, who comments on styles of management, put his finger on one of the report's problems: "What is completely missing from the inquiry team is grassroots representation of any kind from all those who would be affected by the inquiry's findings, namely from doctors, nurses..." He also correctly predicted how the new "managerialism" would play out over the next 30 years: "Management (that is executives) are apparently to provide patients and the community with what management and higher authority think is good for them."<sup>2</sup>

My contention is that the imbalance between the power of managers and doctors, which Griffiths set in train, is harming patients. This imbalance of power plays out in many ways. Managers, who do not have an ethical or regulatory body equivalent to the General Medical Council, can report a doctor to the GMC, and even if the GMC finds no

fault with the doctor's behaviour, the doctor may still find it difficult to get another job in the NHS. There is little or no opportunity for redress in terms of the manager's behaviour.

Doctors, who—after going unsuccessfully through the appropriate internal channels—publicly complain about situations that they consider compromise patient safety, have occasionally been dismissed by their hospital trust.<sup>3</sup> If an employment tribunal finds that a doctor, or other member of staff, was wrongfully dismissed or treated badly by the trust, that doctor may have considerable difficulty obtaining further employment in the NHS.<sup>4</sup>

The GMC advises doctors to "take independent advice on how to take the matter further" if trusts take little or no action about their

concerns.<sup>5</sup> However, although professional help is available, doctors may still have difficulty finding "independent advice" without potential detriment to their future employment in the NHS. A whistleblower emailed me in 2010 to say, "At present, if you whistleblow, you will be dismissed—it's as simple as that!... Once doctors are dismissed, it is virtually impossible to find employment back in the NHS." The cost of defending a wrongful dismissal can be high, and the doctor may have to sign a gagging clause to get any compensation from NHS organisations.<sup>6</sup>

A BMA survey showed that more than half of doctors surveyed had concerns about standards of patient care in their workplace, and some of those who reported their concerns agreed that: "The trust indicated to me that, by speaking up on sensitive issues, my employment could be negatively affected."<sup>7</sup>

Currently managers may sit on, or chair, clinical excellence award committees that advise about recommending doctors for awards.<sup>8</sup> Managers can have considerable influence on the funding of units and appointments to posts within a hospital. At the national level the managerial influence may come from higher up the NHS hierarchy. Units within royal colleges and other national healthcare organisations may be funded partially by grants from the Department of Health, which has significant power of patronage in terms of recommending doctors for national honours.

In 2007, the Department of Health in England commissioned three reports on the regulation of the NHS from three respected US organisations—the Institute for Healthcare Improvement (IHI), the Joint Commission International (JCI), and Rand Corporation.<sup>9</sup> JCI is the international branch of the Joint Commission, which accredits and certifies more than 19 000 healthcare organisations and programmes in the United States.

### Fear and loathing

These reports were submitted to the Department of Health in January and February 2008 but were not published or referred to by the House of Commons Health Select Committee when it debated patient safety in 2009.<sup>10</sup> They were released in January 2010 only as the result of a Freedom of Information Act request. The IHI report says: "The NHS has developed a widespread culture more of fear and compliance, than of learning, innovation and enthusiastic participation in improvement." It also said, "Virtually everyone in the system is looking up (to satisfy an inspector or manager) rather than looking out (to satisfy patients and families)" and "managers 'look up, not out.'"

The IHI report states: "We were struck by the virtual absence of mention of patients and families in the overwhelming majority of our conversations, whether we were discussing aims and ambition for improvement, ideas for improvement,



measurement of progress, or any other topic relevant to quality.” The JCI report says, “A ‘shame and blame’ culture of fear appears to pervade the NHS and at least certain elements of the Department of Health.” It also says, “This culture is affirmed by Healthcare Commission leaders who see public humiliation and CEO [chief executive officer] fear of job loss as the system’s major quality improvement drivers. Although it found “an emerging aspirational tone across the Department of Health (‘world class commissioning,’ ‘clinical excellence pathways’),” there were “few indications of sufficient attention being paid to basic performance improvement efforts.”

These reports were largely dismissed by the Department of Health witnesses to the Mid Staffordshire Public Inquiry. The department’s permanent secretary and its counsel described the IHI and JCI reports as “caricatures.”<sup>11 12</sup> The inquiry counsel stated that “David Nicholson [chief executive of the NHS] told the inquiry that he didn’t believe the JCI report was significant. Indeed, in general, the department witnesses did not accept or even recognise some of the criticisms contained in the American reports, and yet many of those criticisms of a top-down and bullying culture were described by witnesses to the inquiry.”<sup>13</sup> However, the Department of Health acknowl-

edged that those interviewed for the reports—who included Bruce Keogh (medical director, Department of Health), Nigel Crisp (ex-chief executive, NHS), Ian Kennedy (ex-chairman, Healthcare Commission), Andrew Dillon (chief executive of the National Institute for Health and Clinical Excellence), Bernard Crump (ex-chief executive, West Midlands strategic health authority), Sally Davis (chief medical officer, Department of Health, England), Martin Fletcher (chief executive, National Patient Safety Agency), and Niall Dickson (chief executive and registrar, GMC)—might be taken seriously.<sup>14 15</sup>

The BMA was established “To promote the medical and allied sciences, to maintain the honour and interests of the medical profession and to promote the achievement of high quality healthcare.”<sup>16</sup> Emasculation of the medical profession by over-powerful managers or “Stalinist” control from the centre could hinder attempts to improve patient care.<sup>17 18</sup> Making it difficult for doctors to whistleblow could be detrimental for patient care. The primary consideration should be: what is best for patients?

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## Dirty, deluded, and dangerous

Left to their own devices, doctors don’t always do the right thing



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Obstetricians were outraged when, in 1846 in Vienna, Ignaz Semmelweis (left) reduced mortality from puerperal fever in women from 16% to 3% by making doctors and medical students disinfect their hands between performing postmortems and delivering babies: they could not accept any criticism of their professional practice. Semmelweis lost his job and died in a lunatic asylum, while his dirty, deluded, and dangerous colleagues abandoned his policies, continued with their distinguished careers, and returned puerperal mortality to its previous appalling level.

Of course they did not know then, as we do now, that puerperal fever is caused by group A streptococcus, or that normal human skin is colonised by high concentrations of bacteria that transfer to the hands of staff during routine patient care and then on to other patients.<sup>1 2</sup> They would have been shocked to discover that we now have incontrovertible evidence that hand decontamination significantly reduces the transfer of pathogens and the incidence of hospital and healthcare associated infections,<sup>2</sup> and that Semmelweis has been vindicated.

Between the 1890s and the 1950s, the epidemiology of common bacterial pathogens was elucidated. This led to the universal introduction of standard hygiene measures, such as handwashing, no touch technique, gloving and gowning, instrument sterilisation, environmental cleaning, air filtration, the separation of beds, and the isolation of infected patients. Doctors and nurses in the 1950s were still afraid of infections: they washed their hands, made sure their hospitals were clean, and kept strictly to good hygiene practice. They were rewarded by low rates of hospital infection and a certainty that cleanliness was indeed next to godliness.

The introduction of penicillin in the 1940s and the explosion of antibiotic discovery in the 1960s had a further dra-

matic impact on the control of infections, allowing astonishing developments in intensive care medicine, transplantation, and surgery that earlier generations could never have imagined.

All drugs have side effects, and antibiotics came with a terrible one that doctors were too dazzled even to recognise: it made them lose their fear of infection. Infections could be cured with a squirt of antibiotic, or two squirts, or even two antibiotics. And if that didn’t work there was a whole shelf full of new agents that would. Infections had been vanquished; fever hospitals were closed and isolation rooms were reallocated. Doctors and nurses stopped washing their hands and did not protest or even notice when managers stopped cleaning wards. Also, the more relaxed social attitudes of the 1960s were at odds with the need for strictness in hygiene practice. In a startling return to the 1840s, doctors began to resent being told to be clean, and even in 1999 doctors were sending letters to the *BMJ* debunking the effectiveness of handwashing between routine patient contact.<sup>3 4</sup>

On average, doctors decontaminate their hands appropriately only 30% of the time,<sup>1</sup> although they think they are much better than this. In one study, doctors thought they washed their hands between patients 73% of the time, although they actually did this only 9% of the time.<sup>5</sup> Pritchard and Raper were astonished that “doctors can be so extraordinarily self delusional about their behaviour.”<sup>6</sup> Doctors seem equally blind to environmental cleanliness and the need to isolate infected patients. The Healthcare Commission report on the tragic outbreaks of *Clostridium difficile* infection at Maidstone in 2005-6 includes truly shocking photographs of filthy wards and dirty beds that were so close to one another that they were almost touching.<sup>7</sup> In case anyone might think this was a one-off, similar failings of infection control and hygiene practice

## It was the lay public, not doctors, who put pressure on politicians to call a halt to dirty hospitals and uncontrolled cross infection

led to a similar dreadful outbreak at Stoke Mandeville in 2005-6.<sup>8</sup>

With such practices, antibiotic resistant bacteria flourish and hospital infections soar. By 2003, English hospitals reported more than 7000 meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemias a year.<sup>9</sup> Although not all resulted from poor hygiene practice, many of them did. Around 70000 serious MRSA infections, 700000 colonisations, and perhaps seven million failures of infection control must have occurred that year. In 2007, hospitals reported more than 55000 cases of *C difficile* infection,<sup>10</sup> most of which probably resulted from poor infection control and imprudent antibiotic prescribing.

In the end, it was the lay public, not doctors, who put pressure on politicians to call a halt to dirty hospitals and uncontrolled cross infection. Hospitals were required to publish their rates of infection, audit practice, and cleanliness ratings, and to continually reduce their infection rates or face the threat of sackings and fines. For the first time, the 2006 Health Act required healthcare institutions to have appropriate infection prevention and control in place, compliant with a code of practice.

Where decades of education and exhortation had failed, legal strictures had a dramatic impact, even on sceptical doc-

tors, just as they had done on sceptical smokers and drivers. Doctors and nurses were effectively forced to behave, and by 2011 MRSA bacteraemias in English hospitals had fallen by around 86% (from 7700 in 2003-04 to 1114 in 2011-12) and *C difficile* infections by 68% (from 55498 in 2007-08 to 18005 in 2011-12),<sup>9, 10</sup> with associated reductions in mortality.<sup>11, 12</sup> This is one of the most dramatic demonstrations of the effectiveness of good infection control practice (or just good clinical practice) in the medical literature, and it seems to have produced a genuine change in culture. Just as drivers now always use their seat belts and smokers never light up indoors, many doctors now decontaminate their hands between patients without thinking and chastise their colleagues who forget.

However, there are still dirty wards, patients who should be isolated, imprudent antibiotic prescribing, unwashed hands, and many avoidable infections. Some doctors remain sceptical and, like Semmelweis's colleagues all those years ago, still refuse to accept that they may themselves be part of the problem. Christmas is coming with its judgment of the naughty and nice: time to believe and be good.

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## Elite athletes' survival advantage

Could be shared by all through physical activity

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Two linked papers examine longevity in former Olympic athletes and reach different conclusions.<sup>1, 2</sup> Clark and colleagues analysed data on 15174 Olympic medallists from nine countries that have enjoyed success in Olympic Games. The athletes had participated in at least one Olympic Games between 1896 and 2010.<sup>1</sup> The study found that Olympic medallists had a relative survival advantage of 8% compared with matched controls, which translates into 2.8 extra years of life. The second and smaller study by Zwiers and colleagues examined data on 9989 people who competed in Olympic Games between 1896 and 1936.<sup>2</sup> They reported no increase in survival among those who competed in aerobic sports and higher mortality in those who participated in collision and contact sports, including power sports. Indeed, mixed epidemiological evidence pervades this literature, with many studies identifying a lower risk of mortality in previously elite athletes, especially those competing in aerobic events.<sup>3</sup> By contrast, those who compete in power events tend to show less evidence of a survival advantage.<sup>3</sup> What drives these differences?

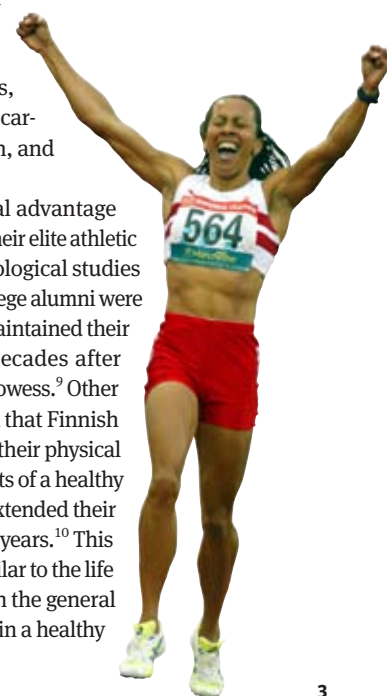
The differences in the findings of the two current studies could be attributed to different mortality datasets, different study periods, differential loss to follow-up (or different statistical methods being used to deal with loss to follow-up<sup>1</sup>), or differences in the characteristics of athletes (for example, Zwiers and colleagues examined all Olympic participants, not just medal winners).<sup>2</sup>

Some elite sportspeople may be influenced by fame and glory, which could confer longevity through increased affluence unless undermined by excessive partying and hazardous risk taking behaviours.<sup>4</sup>

Nonetheless, the epidemiological research shows a slight survival advantage in elite athletes compared with the general

population.<sup>3</sup> However, more than four decades of epidemiological data show that people who do at least 150 minutes a week of moderate to vigorous intensity physical activity also have a survival advantage compared with the inactive general population. Conservative estimates put the survival advantage at just under a year,<sup>5</sup> but the range extends to several years of added survival for physically active people.<sup>6</sup> Interestingly, the upper threshold for benefit seems to be around 300 minutes of exercise a week (about an hour a day), beyond which negligible additional benefit is accrued.<sup>7</sup> Furthermore, recent reviews suggest that excessive endurance training may be associated with harms, particularly in terms of cardiac structure, function, and biomarkers.<sup>6, 8</sup>

The athletes' survival advantage may not be due only to their elite athletic performance. Epidemiological studies have shown that US college alumni were protected only if they maintained their physical activity for decades after their time of sporting prowess.<sup>9</sup> Other researchers have found that Finnish Olympians maintained their physical activity and other aspects of a healthy lifestyle, and that this extended their lives by as much as five years.<sup>10</sup> This health advantage is similar to the life years gained by those in the general population who maintain a healthy





**Meeting recommended levels of physical activity is as important to global health as not smoking**

active lifestyle,<sup>11</sup> with physical activity being the most important health enhancing habit in older people.

Meeting recommended levels of physical activity is as important to global health as not smoking, and inactivity contributes to more than five million deaths a year, more than obesity.<sup>5</sup> Compared with the successes that have been achieved in tobacco control, our inability to improve physical activity is a public health failure, and it is not yet taken seriously enough by many in government and in the medical establishment.<sup>12</sup>

The direct population effect of Olympic medal winners is small—the 448 medal winners in London 2012 studied by Clarke and colleagues comprise about 0.00008% of the adult populations of their countries. Community-wide participation in physical activity needs to be fostered. Olympic athletes could act as role models in organised and integrated efforts to increase physical activity before and after Olympic Games. However, rhetoric and not action abounds. In 2002, planners proposed that the London Olympics might increase the proportion of adults meeting the current guidelines of 150 minutes of physical activity a week from 35% to 70%,

an anticipated population effect large on enthusiasm but well beyond credibility.<sup>13</sup> Studies of previous Olympic Games have found no effect on physical activity levels in the general population,<sup>14 15</sup> probably because of insufficient investment and non-sustained policy and programmatic efforts aimed at tackling inactivity.

Paffenbarger and colleagues cautioned against the mesmerising effects of celebrity athleticism in 2004, suggesting that “Today’s interest in sport is more often vicarious than participatory. We idolize the elite athlete who performs for us, rather than the everyday athlete we could and should become.”<sup>16</sup> Even Hippocrates recognised that “Everything in excess is opposed to nature” and observed that “Walking is man’s best medicine.” Although the evidence points to a small survival effect of being an Olympian, careful reflection suggests that similar health benefits and longevity could be achieved by all of us through regular physical activity. We could and should all award ourselves that personal “gold medal.”

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# BMJ CHRISTMAS APPEAL 2012



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**Sarah Kessler, project manager, Lifebox**

▶ Atul Gawande answers questions about the Lifebox pulse oximeter [www.bmj.com/content/345/bmj.e8407](http://www.bmj.com/content/345/bmj.e8407)

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