Medicine and books

Violence Against Women

Ed Susan Bewley, John Friend, Gillian Mezey
RCOG Press, £35, pp 355
ISBN 1 900364 03 4

The family is consistently presented as the moral foundation of our society, and yet, apart from the police and the military, the family is society's most violent grouping and the home its most violent setting. At some time in their lives, as many as one in four women suffer violence at the hands of the men with whom they have intimate relationships. The 1992 British crime survey showed that violence against women by partners, former partners, and relatives is the most common form of physical interpersonal crime. The total number of domestic assaults in the 12 months covered by the survey was estimated at just over 500 000. Domestic violence, occurring across all social classes and all ethnic groups, makes a huge contribution to the totality of violence and crime in society.

The evidence suggests that domestic violence usually escalates in frequency and severity. By the time a woman's injuries are visible, violence may be a long established pattern. On average, a woman has been assaulted by her partner or former partner 35 times before actually reporting it to the police. For some women, the escalation is fatal: one in five of all murder victims is a woman killed by a partner or former partner, and almost half of all murders of women are killings by a partner or former partner.

None of this is new, but over the past two decades feminist campaigning and scholarship have created a much greater awareness of the extent and prevalence of violence against women. This, in turn, has led to a gradual extension of the definitions of crime to recognise more of the reality of women's experience of violence, and to signal progress, albeit slow, towards zero tolerance.

The NHS and the medical establishment have been relatively slow to acknowledge these shifts of attitude, and the consequent obligation to provide a more substantive response to the pervasive effects of violence against women beyond the minimum treatment of obvious physical injuries.

Violence tends to worsen during pregnancy and has been associated with miscarriages, premature labour, low birth weight, and fetal injury and death. Responding to this particular challenge, the Royal College of Obstetricians and Gynaecologists convened a special study group last summer, bringing obstetricians and gynaecologists together with a range of other experts including midwives, lawyers, police, sociologists, and Women's Aid activists. The aim was to raise awareness of the size and nature of the problem, particularly among doctors, and to formulate recommendations covering clinical practice, education and training, and research.

This excellent book is the product of the group's deliberations. It includes a series of papers offered by a comprehensive range of experts, interspersed with a record of the discussions that took place within the group. In this way, it provides an inspiring account of a profession, sometimes regarded as insular, in the process of opening itself to knowledge and expertise from beyond its traditional boundaries. Only time will tell whether this imported learning will lead to a more sensitive and effective response from ordinary obstetricians and gynaecologists to the needs of women who have been subject to violence. The book deserves such an outcome.

Iona Heath, *general practitioner, Kentish Town Health Centre, London*
Rating: ★★★

European Health Care Reform: Analysis of Current Strategies

Richard B Saltman, Josep Figueras
WHO Regional Office of Europe, £13, pp 310
ISBN 92 890 1336 2

Back to Bismarck: Eastern European Health Care Systems in Transition

Jörgen Marrée, Peter P Groenewegen
Ashgate Avebury, £32.50, pp 138
ISBN 1 85972 617 8

Bismarck, Beveridge, and Semashko—what do these names have in common? Each man has given his name to a model that describes one of the predominant types of statutory financing of Europe's healthcare systems. In fact, the Semashko model, used by countries of the former Eastern bloc, does not exist any more. However, it was the starting point for all countries of central and eastern Europe and of the Commonwealth of Independent States when they decided to move towards the social insurance system (Bismarck model).

Models have always been used to describe and simplify complex things. Reading *European Health Care Reform* reminded me of the breathtaking moment when I first saw the large map of "Biochemical pathways" on the laboratory wall. Nothing is simple in planning, financing, and delivering health care. Whatever you change in the system, it has both anticipated and unexpected consequences, which may be positive or negative. This makes reforming health care extremely challenging.

Everyone who has something to do with health care—as provider or purchaser, patient or doctor—knows that there are many things that could and should be changed. Some kind of reforms are, indeed, taking place in all European countries at the moment.

As already mentioned, the countries of the former Eastern bloc are experiencing a heavy transition period. In other parts of Europe the growing costs of care, ageing of the population, higher levels of chronic disease and disability, increased availability of new treatments, and rising public expectations have increased the pressure to spend more on health care and use the available resources more efficiently.

European Health Care Reform succeeds remarkably well in revealing the complex nature of the challenges faced by physicians, policy makers, and others involved in healthcare reforms. The main, and competing, challenges are to improve the quality of health care, maintain and improve equity, and increase efficiency. This book illustrates Europe's heterogeneous arrangements. The authors concentrate on horizontal comparisons while simultaneously summarising developments in individual countries. The old Western democracies and the countries of central and eastern Europe and the former Soviet states are compared and evaluated in a balanced, useful, and informative way. Being a WHO document, it is surprising that it does not read like a consensus report.

The book has four main headings. The first describes the pressures for reform, and the second presents the main reform strategies. The third part deals with four horizontal themes that are important in the whole discussion: the changing roles of state and market; decentralisation to lower levels of the public sector or to the private sector; patients' empowerment, rights, and choice;

"As these words are written, the world peers into the abyss of an emerging eighth cholera epidemic," says the preface to *Cholera and the Ecology of Vibrio Cholerae* (Chapman and Hall, £45, ISBN 0 412 61220 8). If so then health workers need to update their knowledge which has progressed somewhat since this cartoon in *Punch*.

and the evolving role of public health. The fourth part assesses a number of key strategies that countries have adopted or proposed or are considering.

The text relies on over 30 background papers written by experts and researchers from Europe, Canada, the World Bank, and the WHO. Richard Saltman and Josep Figueras have succeeded extremely well in an almost impossible task. Everything in the complex world of health care makes sense after reading this book — why things have developed in the way they have, why reforms are needed, and what options are available.

The authors use much empirical data in describing the current health situation in Europe and indicating the performance of healthcare systems. However, the conceptual approach is even more interesting. Expertise from several specialties is used: epidemiology, public health, economics, political science, organisational behaviour, and management theory. This type of multidisciplinary approach is seldom successful, but here it works well. The book is, at least for a physician, an excellent introduction to health policy, health economics, and healthcare management.

Back to Bismarck deals with similar questions but only in the countries of central and eastern Europe. It gives a thorough overview of five countries. The book provides useful background material for those who want to know more about recent reforms in these countries, but the approach is much less detailed than in the WHO book.

Sakari Karjalainen, *secretary general, Research Council for Health, Academy of Finland*
Rating: ★★★★, ★★

When and How to Assess Fast-changing Technologies: A Comparative Study of Medical Applications of Four Generic Technologies

G Mowatt, D J Bower, J A Brebner, J A Cairns, A M Grant, L McKee
Health Technology Assessment, £52 (free to NHS and learned bodies), pp 149
ISSN 1366 5278

Every encounter with a patient is an experiment, according to the old saying. Certainly, every encounter during which a new treatment is first used should be. What that experiment should be, however, is not self evident. Whether it should be a randomised clinical trial, as some have urged, is highly debatable and cannot be easily resolved.

It may not ever be possible or desirable to randomise the first patient for a new operation or invasive diagnostic procedure, for much the same reason that the first clinical use of a new drug should not be randomised until preliminary assessments of toxicity have been completed. The introduction of new drugs offers a useful model, as one of my American colleagues suggested in a commentary entitled "Why not an FDA for surgery?"

In phase I of the standard procedure for introducing a new drug its toxicity is first assessed in animals. Similarly, a new surgical technique can be developed in animals. Norman Shumway spent 10 years perfecting cardiac transplantation in the animal laboratory. Anti-vivisectionists may argue that animal research is not necessary, as they did in a Baltimore court many years ago, claiming that Mr R C (later Lord) Brock had not needed animals to introduce the Blalock operation for the treatment of tetralogy of Fallot into England. But Brock happened to be in the gallery of the court and was able to tell the court that Blalock's prior experimental work in dogs had been essential to his innovative operation in children

Phase I may not always be feasible or necessary for surgery or for other invasive procedures. Phase II of drug innovation, on the other hand, is a close parallel to the "learning curve" during which a surgeon or physician learns how to do a new procedure, with phase III consisting of randomised trials if possible and appropriate. The importance of post-marketing surveillance in drug innovation—so called phase IV—is increasingly recognised, and this is equally important for new procedures, to which the authors of the report call attention. Just how important it is to assess the efficacy of a new procedure once it has been accepted for general use may not be widely appreciated. We are, in fact, much better at devising and assessing new treatments than we are at adopting them for general practice.

The authors of this report engaged in a search for a blueprint, a "formula for the timing of health technology assessment," with the hope of developing criteria "for guiding the timing and nature of assessment, and for deciding when [innovations] should become routine services." Towards this end they undertook a series of case studies, a literature search, and interviews with "key individuals associated with the reviewed health technologies." At the end of their search they came to realise that there could be no single, all encompassing formula or protocol, that there are "problems associated with all methods, and hence, a varied, empirical, and iterative approach [gives] the most reliable results."

In the process of looking, they have produced a sophisticated and comprehensive review of the problems encountered in assessing the technologies of medical care. Addressing the long debated issue of whether medical technologies should be randomised at the outset, for example, they encountered the "catch 22" situation that besets so much of evaluative research: the need to postpone assessment "until clinicians have reached an appropriate point on the learning curve, [which] can usually only be recognised retrospectively, by which time clinicians may no longer be prepared to randomise patients."

They also encountered the insoluble ethical dilemma that, in a randomised controlled trial, a patient randomised to the experimental treatment may be exposed to an unknown risk while a patient randomised to control is deprived of the opportunity offered by the new and potentially improved treatment. They summarise other equally daunting ethical problems, such as that randomised controlled trials "might be terminated for 'ethical reasons' once sufficient clinical data [has] been collected to convince the investigator (of the usefulness or otherwise of the health technology), even though further trials might be needed to convince others."

The question asked in this report is not a very useful one. My quibble is with the report's stated purpose: "to try to identify the optimal time at which to start assessing new and fast-evolving health technologies." At the end the authors came to recognise that how a new procedure should most effectively be assessed is apt to vary with every such new treatment.

But, as a review of the problems and methods of medical innovation, it is very successful. It seems to have been written primarily for policy decision makers and "purchasers," and it should be useful in introducing them to the complexities and subtleties of clinical research. It should also be useful to the uninitiated doctor intending to embark on clinical investigation. It will be less useful to the mature investigator.

JP Bunker, *visiting professor, Department of Epidemiology and Public Health, University College London Medical School*
Rating: ★★

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