Assegais are not enough

PERSONAL VIEW **Ian Banks**

When it comes to dividing up the national health cake, there are some who would have it and eat it. The BMA has just produced "A Rational Way Forward for the NHS in England," its response to a motion at its annual representative meeting calling on the BMA Council to address creeping NHS fragmentation and privatisation. It might not be the definitive document stopping Bevan rotating in his grave but it at least addressed the difference between rationing and priority setting. These two words are routinely used interchangeably, despite meaning the opposite of each other. On BBC Radio 4 the two terms are used in the same breath, unfortunately by those who are supposedly protecting the NHS.

It's more than just words or clever semantics. Getting the distinction right is crucial to the debate over the NHS's future and for that matter the BMA suffering a low percentage of junior doctors among its membership, despite an overall increase in numbers. Rationing is the equal distribution of a limited resource. Priority setting is the distribution of a limited resource only to those deemed most needy.

During the second world war, King George VI supposedly waved his ration book while in line for his 2 oz scrag end. Rationing was taken seriously, so seriously that as an equal distribution of limited resources it actually reduced children's mortality, notwithstanding the bombs. People and the police took a dim view of anything that undermined rationing. The black market was so illegal that people went to jail and much worse. But these days, who provides the black market for health care? Us. It's called private medicine. No queuing for the medical equivalent of scrag end if you can afford fillet.

Give young doctors the tools to fight ill health and they will support and defend the NHS

NATIONAL ARMY MUSEUM/BAL

Rationing is not always effective, as demonstrated by the Zulu defeat of the British, shown in this painting, The Battle of Isandlwana, 1879, by Charles Edward Fripp

Rationing is not always effective. During the battle of Isandlwana, South Africa, an overwhelming force of Zulus wiped out an entire British force (along with their support personnel, mainly black men and women). Their quartermaster, conscious of saving the Queen's Purse, rationed each soldier with the amount of rounds he deemed necessary for the conflict. This he based on the number of Zulus, the speed at which they could run, and the rate of fire from a standard British soldier. He got it all correct except the number of Zulus. The quartermaster was out by a factor of 100.

Soon after, the remaining Zulus turned on Rorke's Drift. This small outpost had far fewer infantry and even less ammunition than Isandlwana but both were distributed according to the maximum threat of attack. Zulu courage and bravery is without doubt, but, as the Great War demonstrated, sending troops into concentrated and withering fire will always result in horrendous casualties. More so when armed with nothing more than a large dinner knife. An assegai is no match for a rifle, unless you can get close enough to use it.

Today's UK health professionals face a number of contradictions. They are expected to deliver their services on an equal basis rather than prioritising, which would give a far better impact. Obsession with "targets" further exacerbates the problem. Using out of date equipment and drugs based on economy rather than efficacy, and worse, much worse, they feel that they are infantry pawns for a government more concerned with internal political struggle (not least an illegal war in Iraq) rather than fighting the true common global enemy, public ill health. Targeting limited resources to those patients who would benefit most (priority setting) rather than dishing them out irrespective of need (rationing) makes sense even if it is not politically attractive. For any government really wanting to address inequalities there is no other option.

If the BMA enshrines rationing in its policy it will be perceived as the government's NHS quartermaster. By championing prioritising of care it will however rightfully continue to be the patient's advocate. Never in the history of the NHS, and the BMA, has there been such a chequered NHS when it comes to delivering care to the most needy. Getting the picture clear is vital. Young doctors entering the NHS are looking to the BMA for leadership. Give them the tools to fight ill health and they will support and defend the NHS. Let them feel a part of the war against poverty related ill health while developing their careers and they will join the BMA. Then they will button up their tunics and resist drinking brandy from the medicine cabinet. It is, after all, a flogging offence.

Ian Banks is a part time general practitioner, Northern Ireland, and BMA Council member
ian@medic40.freeserve.co.uk

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No nonsense medicine, p 1117

REVIEW OF THE WEEK

Diagnosing medicine's ills

After decades of resistance, doctors must get over their reluctance to have their performance measured, finds **Jerome P Kassirer**

We Americans were proud to claim that our healthcare system was the best in the world—until we discovered that it wasn't. Reports in the early 1990s that patient care was riddled with medical errors served as an important wake-up call, and within a few years we were scrambling to figure out what to do about it. The revelations that our life expectancy and child mortality were worse than in dozens of other countries added insult to injury, and the enormous variations in practice patterns across the country disclosed that medicine was more like a lone cowboy mentality ("I do it my way, don't bother me with rules or requirements") than scientific practice. For years the only brakes on poor performance were malpractice suits, and they were heavy handed, inadequate governors of practice. But the error mongers spawned evidence based medicine, which in turn begat clinical practice guidelines, a spate of "best practices," and a focus on team and individual clinical performance as never before.

What has emerged is the "quality movement," and its reverberations are experienced by healthcare workers at all levels. Today we wrestle with what to measure, how to measure it, how to report it, and who should be responsible for collecting and analysing the results. Reporting the quality of our performance and attempting to improve it is a form of accountability to which we have been unaccustomed. For many doctors, it represents still another drain on their time, to others an insult to their professionalism, or an intrusion into longstanding modes of practice that have served them and their patients well. Some complain that focusing on specific measures ignores the complexity of a patient's illness. Almost everybody agrees that it isn't easy to design measures that accurately reflect performance. Do we measure process or outcomes? Must we use clinical databases or will billing data suffice?

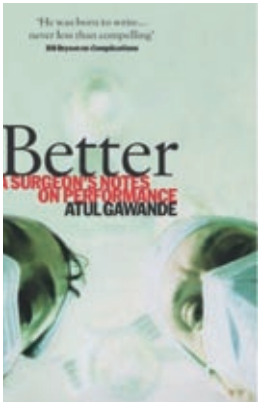
The demand to assess, report, and improve performance is driving some hospital and group practice managers to distraction. Given that the quality movement is still relatively young, opinion varies about which organisations should set the standards. Many, including government agencies, insurers, and not for profit organisations have not only assigned themselves a key role but demand measures so varied that compliance managers find it difficult, burdensome, and expensive to provide them all. One executive of a large hospital network told me that her institution sends reports to seven to 10 different national, state, and local organisations, and she estimated that her organisation is required to report 60 or more unique individual data points. Unfortunately, improving and optimising the quality of care is complicated and difficult. Despite these complexities, aggravations, and added expenses, however, there is little doubt that we have been lax in our attention to the quality of our work.

This backdrop is the setting in which Atul Gawande practises, ruminates about his experiences, and writes. He is an introspective, thoughtful, enthusiastic, and gifted storyteller, one of a tiny cadre of doctors who can explain medicine effectively to the public. This book, a collection of short essays on performance and efforts to better it, covers exceptionally diverse kinds of doctors' activities: from the mundane task of washing hands to avoid hospital infections, to complicity of physicians in executions of prisoners, to efforts to reduce deaths on the battlefield. In each essay the reader is drawn "up front and personal" into Gawande's world and given a vision of what he sees and a sense of what he feels. The stories are a reflection of the soul of medicine.

I am a big fan of Gawande and his writing, but I smiled at the advice he gives to medical students—namely, count something and write something. Good advice, but surely incomplete. I'm sure he would add the next logical imperative—namely, improve something: once you see an obvious defect, join the effort to make medicine more effective, safer, and more humane.

Gawande's stories disclose how hard we try to care for the sick, and how difficult it is to get it right every time. His essays are a brilliant diagnosis of medicine's ills, and they show that it's high time for our profession to take responsibility for the cure. After decades of resistance, we must get over our reluctance to have our performance measured. If the analytical measures of quality aren't perfect, we must stop complaining about them and help to fix them. We must get over our unwillingness to display our results publicly. We must be accountable for what we do well and for what we do wrong; only then can we move towards optimal performance.

Jerome P Kassirer is distinguished professor, Tufts University School of Medicine, Medford, MA, USA jerome.kassirer@tufts.edu



Better: A Surgeon's Notes on Performance
Atul Gawande
Profile Books, £12.99, pp 192
ISBN 978 1 86197 897 4
Rating: ★★★★

Gawande's essays are a brilliant diagnosis of medicine's ills, and they show that it's high time for our profession to take responsibility for the cure

Not sick, just low

FROM THE FRONTLINE
Des Spence

Every time I open the bathroom cabinet the unopened packet of St John's wort stares out at me. Why don't I throw it out? Why did I decide not to take this herbal antidepressant? Was it the feeling of weakness that someone like me, a control freak, could get so low? I am willing to admit to a sustained period of unhappiness that by any biased and highly leading depression questionnaire would have me rated as "clinically" depressed. I am not alone: in the UK last year some 31 million prescriptions for antidepressants were written, a 6% increase on the previous year. Why didn't I seek such treatment?

With all our wealth, comfort, and "me time" these days, why do so many of us find ourselves in the darkest corner of this gilded cage? It is easy to point the finger of blame at the thoughtless GPs, the naive psychiatrists, the greedy drug companies, and the media, which long ago substituted sensationalism for journalism. But this is all too simple, for there is a broader theme at work—the culture of individualism. We have a society that is strong on rights but short on responsibility. And the result? An atomised society in free fall in the chasm between expectation and reality. Our vast media factories pollute the airways with messages that happiness is an absolute entitlement and comes at no personal cost. We are experiencing a global emotional climate change, with extreme storms of behaviour—and this changed climate is melting the icecaps of stoicism and acceptance.

Medicine needs to move away from intervening in mood issues, for we are destabilising the situation further. Esteem is born from overcoming adversity, so when life's problems become an illness, and when coping is seen as denial, what hope is there for our sense of self worth? Depressive pain has a psychological purpose in the same way that physical pain has physiological purpose. Low mood is as normal and as important to our sense of well-being as happiness is. This is not to dismiss depression but merely to free it from the totalitarianism of medicine and reflect the heat of these emotions back into broader society. Family and friends—the people who know the context of our lives—are the natural emotional sump. Exercise, walks in the country, and other such "organic" treatment seem a natural solution to many people, but most of all, healing comes with time.

With 31 million prescriptions and a 6% annual growth, medicine should admit that its offer to "cure" depression was naive and wrong. Drug treatment should be reserved for the very few, not the many. Over the years I have taken many a hard look in that bathroom cabinet mirror—the time for the medical profession to look at its own reflection is long overdue.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk

Five go mad in primary care

THE BEST MEDICINE
Liam Farrell

Raised in rural Ireland, I used to read Enid Blyton just like everybody else, so a locum in the shires a few years ago was just like going home.

On my first morning the vicar waved to me in greeting, like John Major had promised, although I was then a bit surprised to see him slipping off his bike to trade Es with the local hoodies; things sure have changed on Walton's Mountain, I thought, but hey, that's the Church being more relevant, out there on the streets with the kids.

And even more quintessentially English, that night I was called to a murder scene. The body was face down in the local cricket club, blood on his scalp, a bloody cricket bat lying beside him, and the assembled committee looking on in fascination.

The policeman introduced himself as Constable Goode, and I felt I'd known him all my life.

"Cause of death," he pronounced slowly, with the traditional air of intense concentration, writing in a little notebook with the mandatory stubby pencil, "trauma to head by person or persons unknown."

I knew something was required of me, and I rolled the body over. The shirt had been ripped open, there were fresh bruises and burns on the chest, and the deceased had an annoyed expression on his face.

"Not so fast, sergeant," I said (I always address coppers thus—a little bit of harmless flattery goes a long way), "there's not enough blood. I therefore deduce that the head injuries were inflicted after death, as a cunning red herring."

"A red herring?" mused the constable, "in this plaice? Then what was the murder weapon?"

I pointed to the corner of the room. "The defibrillator," I shouted. "J'accuse!"

The club secretary fell to his knees. "OK, I confess," he wailed. "We've had that machine for five years, paid three grand for it. All those fund-raising garden fetes and sponsored walks and tea dances—if I ever see another cucumber sandwich I'm going to vomit. But in all that time we've never had a chance to use it, despite the publicity that people were dying like flies and about how important it was to have one; it's just been sitting there in the corner, laughing at us. So when Walter took a weak turn at the bar, we saw our chance; he fought bravely but we got him down in the end."

Then a small curly-haired boy (or girl) popped her (or his) head round the door.

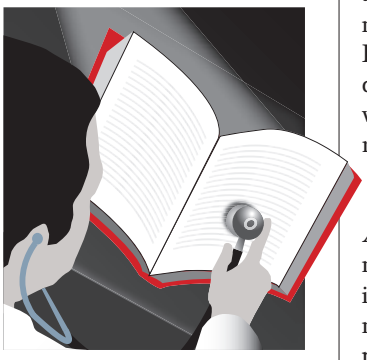
"Too late George," said the constable, "this case is closed."

"F**** it," said George, "what'll I do with all this ginger beer?"

Liam Farrell is a general practitioner, Crossmaglen, County Armagh William.Farrell@528.gp.n-i.nhs.uk

Stalwart of the county

BETWEEN THE LINES
Theodore Dalrymple



My Shropshire lad was not a soldier of the Queen, but he was a soldier against the deadening army of health and safety

I knew a Shropshire lad once and I liked him enormously. I met him not in those blue remembered hills, but in a far off tropical country in which I was working, and to which he also came for work. He had diabetes and he arrived for a check-up. He was a large man, both muscular and fat.

"I suppose," I said, "that you are careful with your diet."

"Not at all," he replied.

I soon discovered that he loved rich food, good drink, and company (mine soon to be included).

"There's not much point in my telling you that your habits are not good for you, is there?" I said. Indeed there wasn't: he had opted for a short but merry life, and I was glad to get the subject out of the way. What a relief it was to meet someone who had the courage to reject medical advice without pretending otherwise!

It was strange, though, to talk to him about Shropshire—a county I knew quite well because I had once done a locum in a small town there—in that verdant tropic where the temperature rarely varied by more than a degree or two, and where the daylight lasted exactly 12 hours all year round.

I mentioned that, when I was in Shropshire, half my time was occupied by patients who lived in a single road. "Ah, yes," he said, and then named the road (I still remember its name, though I won't reveal it now), notorious at the time throughout the county for domestic violence and other such ways of staving off boredom.

Alas, he did die young, just as predicted, a few years later. Of course I was very sorry, and yet his death confirmed me in my admiration for him: he met his end unafraid and unself-pityingly. He had made his choice and therefore he made no complaint. He was a man who did not measure life with the straight ruler of time.

I cannot read A E Housman's *A Shropshire Lad* now without thinking of him. A large number of the poems concern, or mention, the early deaths of Shropshire lads (and lasses), although what was considered early with regard to death in those days—1896—was a good deal earlier than in ours. Sometimes, in my more reactionary moments, I wonder whether a familiarity with death makes for a deeper character.

Does not this verse fit my Shropshire lad? "Oh you had forethought, you could reason, / And saw your road and where it led, / And early wise and brave in season, / Put the pistol to your head." Or again: "Come you home a hero, / Or come not home at all, / The lads you leave will mind you, / Till Ludlow tower shall fall."

Of course, my Shropshire lad was not a soldier of the Queen, but he was a soldier against the deadening army of health and safety, and in my eyes at least a hero. He truly might have said: "'Tis late to hearken, late to smile, / But better late than never. / I shall have lived a little while / Before I die for ever."

So to him I say: "Turn to rest, no dreams, no waking; / And here, man, here's the wreath I've made: / 'Tis not a gift that's worth the taking, / But wear it and it will not fade."

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

The Madness of King George

Film released 1994

A re-working of Alan Bennett's original stage play, *The Madness of King George*, is a classic of British cinema. Nigel Hawthorne (of television's *Yes Minister* fame) stars as the eccentric King George III whose bizarre behaviour, caused by what is now thought to have been an episode of acute porphyria, causes problems of propriety for his family, his subjects, and for the country as a whole.

The story begins in 1788 with the king still finding it difficult to come to terms with the loss of the colonies in North America. The then prime minister, William Pitt the Younger, and the king are far from great friends, but they have a way of getting on. Indeed Pitt feels more secure in his own position with the somewhat malleable George on the throne. The king busies himself with other activities—outdoor sport and family life. His wife, the Germanic Queen Charlotte (Helen Mirren), has borne him 15 children, and their relationship is a tender and genuine love affair.

Things begin to go awry, however, when George's mental state deteriorates. Accompanied by symptoms of acute abdominal pain, discoloured urine, and fever, George's uninhibited behaviour is increasingly outrageous and it soon becomes clear that he is not fit to rule. His son and heir, the opportunistic and idle prince of Wales (Rupert Everett), eyes a chance for power and with the help of Pitt's rival politician, Charles Fox, a bill is proposed to establish the prince regent, reigning in the king's stead.

KOBAL

"I am the king of England." "No, sir, you are the patient."

The portrayal of the medical profession is of great interest. Initially three traditional physicians, with establishment backgrounds and hairpieces to match, are consulted. They dare not ask their regal patient a direct question nor look him in the eye, let alone lay their hands upon him. They prescribe a regimen of blistering, purgatives, and hot baths, but there is no improvement. As the king's condition deteriorates, Dr Willis (Ian Holm), a gritty doctor/pastor from Lincolnshire with experience of treating such symptoms, is summoned. From the outset he is far less mild mannered and makes it clear that he will not tolerate any misbehaviour by the king. The wonderful scene in which doctor and king first meet ends as follows: "I am the King of England." "No, sir, you are the patient." By luck or good judgment, George's convalescence at Kew Gardens is a success. He returns to parliament to reaffirm his position on the throne and to lambast his plotting son.

In reality, the king experienced recurrent episodes of delirium and ultimately the regency was established. Research has subsequently implicated high arsenic levels in the king's antimony powders as responsible for the porphyria. What is certain is that *The Madness of King George* is a British historical drama of the highest calibre.

John Beard, FY2 doctor, University Hospital Birmingham
johnbeard@doctors.org.uk