reviews

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Epidemic of Care: A Call for Safer, Better, and More Accountable Health Care

George C Halvorson, George J Isham

Jossey-Bass, \$30, pp 304
ISBN 0 7879 6888 9
www.wiley.com

Rating: ★★★

American health care is ailing again after a period of remission brought about by some no longer effective medicine administered by managed care. Premiums have returned to double digit escalations, prices of prescription drugs are soaring, malpractice premiums are out of control—and the populace is getting fatter each day.

All of this is documented—along with some possible solutions—in what may be one of the more lucid explanations of what is going on in US health care. The authors are well qualified to do the explaining, as both have top jobs in US healthcare organisations: George Halvorson is chairman and chief executive officer of Kaiser Permanente, and George Isham is medical director of HealthPartners.

The chief ailment, they say, is a public that wants unlimited care while not taking enough responsibility for its own health. Thus the number of people with diabetes in the United States has gone up by more than 33% since 1990, “a fact that shouldn’t surprise anyone since the number of middle-aged Americans who are definably obese increased from 14.4% in 1982 to 26.7% in 1999.” Another contributor to the country’s \$1500bn (£900bn; €1300bn) annual healthcare expenditure is medicine’s own capacity to produce miracles—and the public’s demand that it do so without regard to cost. For example, a 500 g premature baby can now be saved, but, say Halvorson and Isham, “it can easily cost a million dollars.”

And, they continue, “we can now insert enough prosthetic devices (knees, hips, ankles) and transplanted organs (hearts, lungs, kidneys, corneas) to create a six million dollar man or woman.”

The epidemic of care is exacerbated by inefficiency, inconsistency, unaccountability, and lack of focus, say the authors, who nonetheless describe themselves as “cynics—and optimists.” Their treatment is propounded in numerous subheadings throughout the book, such as “An automated medical record is the critical next step,” “What happens when lawyers practise medicine?” and “Targeted internet communications can get best practices to all relevant physicians.”

What it boils down to, though, is accountability through consistent and standardised patterns of care, a cost-benefit assessment of the value of medical “miracles,” automation of support tools for doctors, competition within the healthcare marketplace, and emphasis on prevention.

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Improving Patient Safety: Insights from American, Australian and British Healthcare

Eds Stuart Emslie, Kirstine Knox, Martin Pickstone

Emergency Care Research
Institute and the Department of
Health, £35, pp 104
ISBN 0941417751

Rating: ★★★

What ensued when a medical devices officer decided to explore the cupboards at his hospital is one of the most attention grabbing parts of this book. Chris Quinn, from Newcastle upon Tyne Hospitals NHS Trust, found more than 40 types of infusion pump, 25 of which were obsolete, and discovered that no nurse had had competency based training in their use. An increase in the number of infusion incidents from 1993 to 1996 at the trust

has now been reversed, thanks to a training programme and the growth of what Mr Quinn describes as “a culture of safety.”

The theme of a safety culture runs through the book, which comprises abridged transcripts of presentations at a conference to introduce the UK’s National Patient Safety Agency in 2001 and is edited by the speakers. The first few presentations are concerned with steps taken by the NHS since 2000 to emphasise the safety of patients, and with the launch of the National Patient Safety Agency. For example, Stuart Emslie, the then head of controls assurance at the Department of Health, outlines the new national system for learning from adverse incidents in the context of the governance and controls assurance agenda. He adds that it could be argued that underinvestment in health service management is a major factor in the high incidence of preventable harm to patients. Another contributor, health minister Lord Hunt, points out that prolonged hospital stays as a result of adverse events cost the NHS at least £2bn (\$3.2bn; €2.8bn) a year.

Contributors from the United States, Australia, and New Zealand add an international dimension to the book. Dr Paul Barach, from the University of Chicago’s Center for Patient Safety, talks of improving safety of patients by “replacing the frag-

mented approach by teamwork and inviting the patient into the system,” while Dr James Bagian, director of the Veterans Health Administration’s National Center for Patient Safety, warns of the potentially dire consequences of failing to protect the confidentiality of people making reports. He says that when New Zealand’s civil aviation authority revealed the name of a captain who had made a report, it lost the trust of the aviation community and was disbanded. Professor Bill Runciman, president of the Australian Patient Safety Foundation, discusses improvements in the prescribing of non-steroidal anti-inflammatory drugs and the use of pulse oximeters.

The book is particularly strong on solutions to patient safety problems. Some parts are starting to look dated—for example, on the work of the National Patient Safety Agency, as many developments have taken place since October 2001—but overall the book is a valuable read for people who are thinking about and implementing measures to implement patient safety.

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A colleague of PA on the board of the *Health Care Risk Report* is Stuart Emslie, one of the book’s editors.

An expert witness falls from grace

Sir Roy Meadow in the media firing line

Since the Court of Appeal cleared Sally Clark in January of murdering her two babies and, more recently, a jury took just 90 minutes to acquit Trupti Patel of triple murder, Sir Roy Meadow, professor of paediatrics and expert witness, has faced a growing critical onslaught from press and broadcast journalists.

But it was not so long ago that the media was ringing enthusiastically to Sir Roy's soundbites. These included the one in 73 million statistic he cited in the Clark trial as the chance of a cot death occurring twice in the same family, or the so called Meadow's law—that one cot death is a tragedy, two suspicious, three murder—put forward in the Patel case.

So what is going on? Have the media reappraised the eminent professor's work, considered new evidence in the field of genetics, studied the defects in the UK pathology system, and generally got to grips with the multitude of complex, interdependent issues that are at the heart of the Clark and Patel cases?

Or is it more likely that while once stories in which dead infants, vilified mothers, and trailblazing professors proved too good to be true, now stories about dead infants, wronged mothers, and professors ready to be pulled off pedestals are proving just as irresistible.

Joyce Epstein, director of the Foundation for the Study of Infant Deaths, says that few journalists want even to attempt to tackle the issues involved. "No matter how much we try to tell the media there are serious difficulties about what kicks into place or doesn't kick into place when a baby dies suddenly—that it's not one person or two but the system that's at fault—it's not sexy enough for them," she says. "The media always want to simplify things and identify a villain of the piece."

For former journalist and MP Martin Bell, though, things are not that simple. Closely involved in the Clark case, he particularly commends the work of investigative journalist John Sweeney, whose prolific output, including a Radio 4 *File on Four* programme and a BBC 2 documentary (*BMJ* 2003;326:402), has proved pivotal in the public reassessing of Sir Roy's standing.

Bell says: "Journalists must be able to point the finger without being accused of running a witchhunt. [Sir Roy] has a right not to be convicted by the media but, my goodness, the media has certainly shown there's a case to be answered."

Sweeney says the difference between rigorous journalism and a witchhunt is that with the former you have evidence. He adds: "I have evidence to say that some people are more prone to cot death than

CHRIS YOUNG/PA

A campaigner against Meadow's medical evidence, outside the High Court in London

the general population. But Meadow, it seems, has no evidence to back up his 'Meadow's law'—other than his own experiences—and that's in a databank which he shredded."

Sweeney is something of an exception among journalists, however, a tenacious campaigner who has been following and continuously researching his story for more than two years.

Stephen Clark believes the vast majority of journalists at his wife's trial were uninterested in the medical evidence, appearing either unable or unwilling to understand it. Sir Roy's "one in 73 million" statistic was a godsend to them, he says, used to imply that Sally must be guilty.

"In order to free Sally," he explains, "not only did we have to prove how our babies died but we also had to turn the press around and get them on our side."

History shows that that is, eventually, what did happen. However, as Stephen Clark points out: "Even then, very few of the journalists were prepared to try to understand the medical evidence, the appalling errors in the pathology . . . Instead, the coverage concentrated almost exclusively on the false statistic because now, as before, it was an easy soundbite."

He adds: "The [media] bandwagon has since developed its own momentum as it accelerates directly towards Professor Meadow."

Sue Stapely, the lawyer-turned-media consultant who worked on the Clark campaign, notes the media u turn too. She points out: "If you are going to carve a career for yourself writing and broadcasting and giving evidence in court then you run the risk if your evidence is questioned of being treated like this."

Sir Roy's views on the changing media climate remain private; he did not return the *BMJ*'s calls.

But, fair or unfair, the views of Stephen Clark will be understandable to most. "Forgive me, if I cannot find it within myself to feel sympathy for the professor," he told the *BMJ*. "He is now being beaten with the same false evidence with which he once beat us."

"Nothing which now happens to him can be as bad as what happened to an innocent, bereaved mother, her surviving little boy, and her loving husband."

Naomi Marks freelance journalist, Brighton

WEBSITE OF THE WEEK

Homelessness and health A paper in this week's *BMJ* (p 81) looks at risk factors for early death among homeless people. The health needs of homeless people are complex and challenging; homeless people represent a group most in need of health care yet least likely to receive it. Can the internet help us learn more about their needs and begin to find a way of providing solutions?

Excellent places to start any factfinding mission on homelessness are the websites of the national homeless organisations Crisis (www.crisis.org.uk/) and Shelter (www.shelter.org.uk). In particular, www.crisis.org.uk/research/health.php and www.shelter.org.uk/images/pdfs/factsheets/health_factsheet.pdf both provide comprehensive factsheets and useful references for further research.

www.homelesspages.org.uk is a good portal for homelessness. It has a section on health containing links to 44 resources, covering a broad spectrum of relevant issues from hypothermia to nutrition. A word of warning, though: some of the most interesting links are to publications that are out of print but that can be emailed upon request.

More practical, though not comprehensive, advice on adapting clinical practices for homeless patients can be found at the site of the US National Health Care for the Homeless Council (www.nhchc.org/Network). Topics covered include tuberculosis and HIV/AIDS, as well as a recent addition on severe acute respiratory syndrome (SARS). A similar Australian site aimed at non-medical support workers (www.hhb.foxchange.net.au/index.html) provides practical information on subjects such as alcoholism, mental health, and medications.

As some of the major problems affecting homeless people are related to mental health, sites such that of the UK Mental Health Foundation (www.mentalhealth.org.uk) and the US National Resource Center on Homelessness and Mental Illness (www.nrhcni.com) are invaluable.

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PERSONAL VIEW

A time to ask what you want of WHO

Five years ago Dr Gro Harlem Brundtland took over a largely demoralised World Health Organization from Hiroshi Nakajima and initiated a reform to give WHO new relevance to current public health needs. Technical staff warmly welcomed the strong emphasis she placed on evidence based advocacy, openness and transparency, and unity within the organisation.

Last year it became clear that Dr Brundtland would not seek a second term and on 21 July Jong-Wook Lee will succeed her as director general. However, Dr Lee is not inheriting a reinvigorated organisation or one that is close to achieving the three overarching principles instigated by the Brundtland reform.

Dr Brundtland did succeed in getting health recognised as an issue on the global political agenda and in drawing attention to the economically debilitating effects of ill health. However, this gain may have been achieved at the expense of other priorities.

Many of the public health issues that face us today are not controversial. There are no advocates of malaria, polio, HIV/AIDS, etc, so everyone can agree to eliminate them, although there will be debate over how. Public health, however, is also contingent on less clear cut issues, particularly in the area of environment and health, where the detriment and the cause are not so obviously associated, or visible, and the balance between societal benefit and individual detriment contentious. For example, in the case of nuclear power generation, the waste disposal problem remains largely unsolved and the health effects of low dose exposure are a matter for controversy, but there is minimal contribution to global climate change. It is surely in situations such as this that a sound evidence based approach is critically important and it is here where the Brundtland reform has most crucially failed.

Two *World Health Reports*, in 2000 and 2002, both evidence based, have been criticised on methodological grounds. A few weeks ago, writing in the *Lancet*, the editor in chief of the 2000 report alleged manipulation of the evidence, and autocracy over decision making by senior management (*Lancet* 2003;361:1817-20). These reports are the visible face of the failure to manage an evidence based policy; as with an iceberg, much more lies beneath the surface.

WHO's decision making on issues related to public health and ionising radiation—my area of expertise—has been dictated to a large degree by the perceived needs of the International Atomic Energy Agency. Decisions, contrary to the evidence, have been made autocratically and without transparency. For example, the effort

devoted to the creation of a facility dedicated to providing public health advice in the event of nuclear emergencies—such as the detonation of a “dirty bomb”—was annulled with the closure of the Helsinki Project Office, without the provision of an alternative or a reason. The “turf war” between the European Regional Office and Geneva in the Nakajima era—for example, over responsibility for the follow up to the Chernobyl disaster—has raged unabated throughout the Brundtland term.

It is surely important that the scourges of the last century are eliminated. Dr Lee, a vaccines specialist, may well prove to be the right person for that. But what of the more insidious threats, particularly to economically developed countries, where pressures to exploit existing and new technologies commercially—for example, mobile telephones and some aspects of nanotechnology—pose potential public health risks? In the European Regional Office the one time professional capacities in chemical safety, occupational health, wastes management, and radiation and health have been dispensed with within the last year or so following

the closure of the environment and health department, once a globally respected entity. The decimation has been hardly less severe in Geneva.

Access to health through appropriately priced drugs for the world's poorest is surely a vital and worthy cause. But equally, so is the anticipation and prevention of morbidity and mortality through the exploitation of the existing and rapidly growing scientific knowledge, to say nothing of the wellbeing associated with an environment that poses no threat to health from the food we eat, the air we breathe, and the water we drink.

It is surely time to ask ourselves what we want from WHO. An organisation that retrospectively dispenses pills and counts the sick and dead is one thing; an organisation that proactively harnesses the best scientific decision making apparatus worldwide and fearlessly evaluates and confronts proposed technological innovation with sound evidence, is another. If this latter role is wanted, then a major reform of the existing senior management culture is essential. It is a matter for the member states to decide. Dr Lee's term provides the opportunity.

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The author was employed as radiation scientist and regional adviser by the European Regional Office of WHO from September 1991 to May 2003. The views expressed are those of the author and are not necessarily those of either the University of Kuopio or WHO.

SOUNDINGS

Glue, spark, or string?

Or is it more like just oiling the wheels? Money, it seems, comes into it, with more than a suspicion that it might be funny money: the now-you-see-it-now-you-don't kind that appeared when fundholding began, then vanished, mirage-like, as later applicants were punished for their tardiness.

So, glue, spark, string (all analogies were on offer), or just money? Even after a three hour session with an enthusiastic team from Edinburgh, few of us here in Auchendreich were much the wiser about the Scottish Executive's latest nostrum for the transformation of our NHS: the managed clinical consortium (MCC).

Certainly the MCC presentation was impressive, not just for its virtuoso PowerPoint. Drawing on all the latest management theory, MCCs will, we were told, offer low friction, high gain, information rich, user friendly virtual networks that cross boundaries, transcend distance, and maximise added value over entire clinical journeys through complex healthcare systems.

“Eh, does that mean we're all going to be told what to do?” a urologist asked. The lead presenter smiled. “That's a question that comes up quite often. No, not at all. Clinically led, fully automated quality control systems are fundamentally supportive, with compliance and significant aberrance handled alike in strict confidence, through anonymised datasets, coded feedback, and lockdown password control.”

The urologist nodded thoughtfully. There was no stopping the lead presenter: “If anything, most clinicians feel liberated by what MCCs can do. And while they're not a panacea . . .” To our surprise she went on to cite more than a dozen problems they might address, including waiting lists, consultant understaffing, and—intriguingly—the European working time directive.

Any worries? Well, the pilot consortium had met difficulties arising from the 59 different IT systems in use; and burnout was a significant issue for both IT people and clinical leadership. But such minor matters were essentially front loaded and transitional, with no real bearing on the national rollout of a brand new initiative of limitless potential.

As evening sunlight flooded the chairman's hospitality suite in our otherwise cramped new PFI, the meeting drew to its close. Evangelical fervour had won no converts. Discussion had elicited the kind of scepticism to be expected in Auchendreich. So, as with all NHS fads, Auchendreich will simply wait and see.

Colin Douglas *doctor and novelist, Edinburgh*