VIEWS & REVIEWS

The great NHS communication breakdown

PERSONAL VIEW **Peter Davies**

If you want to see why the NHS is a failing organisation consider these selected examples, chosen from a wide field.

A patient of mine had a heart attack in a seaside town and was well treated by the local district general hospital. She arrived back in Halifax, but I have no record of anything that happened in the other town. She eventually came to see me four weeks later, as she was running out of pills. The good work the hospital had done was undone while I struggled to get the information I needed to continue to provide care. Her husband (an active type, fiercely protective, and usefully agitated) phoned the hospital and got them to fax the preliminary discharge letter to me. Apparently someone at the hospital had promised him that this was to have been done some time before the patient's appointment, but for whatever reason it hadn't been.

Another patient saw the neurologist for worsening epilepsy. A scan was arranged and was done quickly in October. By January the patient had not heard anything about the scan or a follow-up appointment. She wanted to know the result and what it meant. I would happily have told her this but could not as I did not have the information to hand. The treatment is not the problem, the patient is not the problem—the failure of information transfer is the problem.

There is no sign that Darzi's recent review has even considered this major daily impediment to good care of our patients

The radiographer tells them, "It will be with your doctor in 10 days' time." Two to three weeks later the patient has managed to get an appointment with me, and I feel like an idiot sitting there saying, "The hospital may have said that, but in practice the results take much longer." I am thinking, "This is a poor service I am providing," and, "You

Time to sort out the mess

are the fifth person I have told this to this month." My secretaries phone the radiology department, and the report is faxed back. The patient will end up coming back for another appointment, or the surgery will over-run, as it takes more than 10 minutes in organising time to get the fax.

What a waste of time for the patient, the general practitioner, the practice staff, and the hospital staff. What a lot of unnecessary extra hassle that need never have been generated at all. What a prime example of over-promising and under-delivering. What a recipe for mistakes to occur and for continuity to be lost. What an example of the producer's side of the NHS failing to make the care of patients its first concern. What an example of casual unkindness, of the sort that happens daily throughout the NHS. Inevitably, patients who undergo investigations of their symptoms will be worried. But how cruel it is to add to this unavoidable burden by making patients wait too long for results and not having them ready when promised.

Any general practitioner from anywhere in Britain, at any time in the history of the NHS, could give numerous examples of missing, incomplete, inaccurate, and delayed information from hospitals. (And I

know that the hospital folk can give many examples of it happening the other way too.) But if any reform of the NHS is to succeed, it should make it a top priority to correct such failure in the passing of information between primary and secondary care. The NHS is spending £12bn on an IT system that shows no sign of acknowledging this as a problem.

At present the problem does not seem to be on anyone's radar and does not get measured in trusts' star ratings. It is considered so unimportant that well paid senior NHS managers have convened committees to consider outsourcing typing of medical reports to India to save money on hardworking and under-appreciated medical secretaries. These senior managers have no idea of how many loose ends their clerical and secretarial staff are sorting out. And they have no specific incentive to improve the system. Our local clinical governance networks routinely ignore reports of the problems or, worse, shrug their shoulders and say, "It's always been like this." In Leeds recently 120 sacks of clinical mail were found unsorted in the hospital's mailroom (www.yorkshireeveningpost.co.uk/news/Leeds-hospital39s-mail-DUMPED.4232883.jp).

We are moving to ever shorter stays of patients in hospitals and more rapid assessment. And yet the necessary corollary of this move—accurate and timely transfer of information between secondary and primary care—is only rarely happening.

Can we call this failure of information transfer care at all? Isn't the truth that this institutional behaviour of non-communication is just carelessness and neglect? How much better it would be for patients, for staff, and for the NHS if this mess was sorted. There is no sign that Ara Darzi's recent review of the NHS has even considered this major daily impediment to good care of our patients.

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Why I've reinstated the coconut milk and ghee on the weekly shopping list
Trisha Greenhalgh, p 178

REVIEW OF THE WEEK

The secret of HIV control is in the back streets

An “entertaining rant” about the foibles of international aid for HIV prevention is underpinned by rigorous research, finds **Joanna Busza**

A major crackdown on prostitution is under way in Cambodia. Over the past few weeks police have been rounding up sex workers and closing down brothels. In response, 200 sex workers marched through Phnom Penh to protest against the human rights abuses—including extortion, intimidation, and rape—accompanying the mass arrests. Both sides have used the rhetoric of HIV prevention to support their cause: the police argue that commercial sex fuels the epidemic and thus should be abolished; the sex workers point out that forcing them into hiding limits their access to condoms and treatment for sexually transmitted infections.

This is the kind of scenario that makes the journalist turned epidemiologist Elizabeth Pisani's blood boil, motivating her to write *The Wisdom of Whores*, an entertaining rant against the seemingly irreconcilable gap between what she calls Planet Epidemiology and Planet Politics. The book is full of similar examples, demonstrating how simple, effective HIV prevention measures that are based on sound evidence are routinely ignored in favour of ideological positions or are sidelined by those who seek to co-opt HIV funding for other aims.

Pisani takes aim at everyone guilty of “bad science”—not just the religious fanatics who have turned the Bush administration's HIV and AIDS policy into a moralistic farce but also the “AIDS mafia,” those activists, consultants, and United Nations technocrats who talk about “poverty and gender inequality” instead of sex and drugs. The real problem with AIDS, she says, is that, except in a few hard hit countries in Africa, the virus is almost exclusively spread through shared syringes, anal sex between men, and commercial sex. So although the data indicate that “junkies,” “gays,” and “hookers” are the groups most in need of effective services, it is such groups that remain least likely to get them, as they lack political clout and because most policy makers are reluctant to take any action that could be seen as condoning or, worse, encouraging stigmatised behaviours.

The first part of the book sets out how data on HIV transmission have been gathered, analysed, used, and manipulated. Pisani is renowned for having developed among the best behavioural surveillance methods around, and she describes putting them into practice with poignancy and humour, relating anecdotes about getting stopped by the police with a cooler full of blood

samples strapped to her motorbike or traipsing through muddy alleyways between karaoke bars with an army of clipboard wielding fieldworkers.

Pisani also talks a lot about journalistic “beat up”: exaggerating a story to increase sales. As an enthusiastic number cruncher for UNAIDS in the early 1990s, she applied this skill to reports with gusto, trying to portray a generalised epidemic around every corner. This was partly because advocating services for the “dregs of society” is rarely successful and partly out of the naive hope that a big crisis would attract big money that could then be channelled into effective prevention. “We argued quite truthfully that men who inject, men who have sex with one another, and men who buy sex are likely to pass HIV on to their innocent wives,” Pisani writes. “And then came the sleight of hand. Once innocent wives were infected, we implied, HIV would blaze through the ‘general population’ . . . We weren't making anything up. But once we got the numbers, we were certainly presenting them in their worst light.”

The book's second part describes how cumulative “beat ups” backfired, leading to a bloated HIV and AIDS industry divorced from the realities of good public health. As AIDS programmes attracted greater funding, so too they attracted all manner of UN agencies, development institutions, and experts from a range of sectors, diluting focused efforts at prevention. Projects get double funded, organisations compete for the same territory, and there is no accountability regarding the effects of programmes on rates of transmission of HIV. “The result” states Pisani, “is a colossal waste of taxpayers' money.”

In that respect the book continues a long tradition of exposés of the international aid sector. Pisani paints herself as an iconoclast, someone who battled against the tide and is now airing the dirty linen in public at the expense of her future career in HIV prevention. This seems a bit of a “beat up” in itself: most of her criticisms are regularly heard at conferences and planning meetings. Few other insiders will really be shocked by her treatise, and many have similar tales. But Pisani deserves credit for setting forth those arguments in such eloquent language, backed by rigorous research and painstaking attention to detail.

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The Wisdom of Whores: Bureaucrats, Brothels, and the Business of AIDS

Elizabeth Pisani

Granta Books, £17.99, pp 372

ISBN 978 1 84708 000 4

Rating: ★★★★★

Pisani takes aim at everyone guilty of “bad science,” not just the religious fanatics who have turned the Bush administration's HIV and AIDS policy into a moralistic farce but also the “AIDS mafia”

Spam medicine

FROM THE
FRONTLINE
Des Spence

You know all those “Dearest friend” emails offering a half share of \$30m from the estate of a Nigerian oil boss killed in an air crash? Or the authentic looking “urgent update” from banks at which we have no account? And the cleverly misspelt variations on Viagra that escape the spam guard? I delete all these fakes. Likewise, an email about female hypoactive sexual desire disorder was heading for the trash, until I realised that this concerned a real job offer, forwarded by a university academic.

The drug industry complains that it is misrepresented and that it seeks to serve the health of all humanity, flatly refuting allegations of disease mongering and describing research into “me too” drugs as “important.” The industry is angry at the suggestion that it creates medical experts and tries to build prestige disease brands. Odd, then, that this email says it is “aimed at finding Opinion Leaders . . . whose work will influence the future management and therapy of Female Hypoactive Sexual Desire Disorder . . . Individuals may potentially be invited by the pharmaceutical company who has commissioned the study to participate in one of its medical activities such as advisory boards, clinical trials or speaking engagements.” Now this may be innocent headhunting, but it smacks of targeting and developing opinion leaders with the lure of consultancy fees and research.

But even more troubling is the legitimacy of female hypoactive sexual desire disorder. I understand that it is “defined” in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), but Father Christmas and the Easter bunny probably get a code in this Hollywood-esque textbook. For developing the disease brand is crucial—by raising its profile through articles, the use of celebrities, and the all important legitimising medical expert. “Experts” estimate that 40% of women are “sufferers.” This is peddling simplicity where there is only complexity. Sometimes this “problem” is presented even as a feminist struggle for equality, but in reality it is merely cynical manipulation. The usual waste product of this pharmaceutical activity is to pollute and poison the stream of life: your weaknesses (sadness, baldness, low libido) mean that you are inadequate and “ill.”

This is an industry that focuses on lifestyle while the world’s poor are left to the ravages of tropical illness and to the charity of the likes of the Gates Foundation. Criticism has provoked the industry into saying that it is committed to change, but it seems that old habits die hard. It should make me angry, but it just makes me sad.

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From the archive: see also *BMJ* 2003;326:45; *BMJ* 2005;330:192-4.

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Anyone for Club Med?

OUTSIDE THE BOX
Trisha Greenhalgh

A group of Spanish epidemiologists recently published a paper in the *BMJ* offering evidence that we can reduce our relative risk of developing diabetes by 83% by following a strict Mediterranean diet (*BMJ* 2008;336:1348-51). In view of my family history of the condition I made a unilateral (and, in retrospect, foolish) decision to amend the whole family’s diet.

The paper describes a Mediterranean diet as one “rich in olive oil, plant based foods (fruits, vegetables, and legumes), and fibre but low in meats.” My animal protein comes from battered fish (every Friday, without fail) and soft boiled eggs, so I had plenty of room for improvement, despite describing my diet as “vegetarian.”

The other day I proudly served up an aubergine, basil, and tomato casserole with couscous. The family asked what else was coming. Nothing—this is the main course.

Hmmm. No mashed potato then? Spouse covered his in a generous grating of Cheddar cheese. The kids asked whether I minded if they fried up some bacon to go with it.

Don’t get me wrong: my teenagers are no junk food junkies. For years they have been coming home from school to find notes on the kitchen table: “Home late, ingredients in fridge—Mum.” They know their coriander from their cardamom. It’s good to come home from a four hour committee meeting to find the boys in aprons in the kitchen and another wholesome, creative curry bubbling in the pot.

I had always assumed it was an anthropologist who challenged the population to “tell me what you eat and I’ll tell you who you are,” but actually it was the 18th century French politician Jean Anthelme Brillat-Savarin (who, like everyone else these days, has a page on Wikipedia) in his book *Méditations de*

Gastronomie Transcendante (*Meditations on Transcendental Gastronomy*).

Once humankind has moved beyond subsistence, food is not really about staying alive or even of staying healthy but about social pleasure and symbolic meaning. We put effort into making food, and particularly into making it tasty, because this is one of the most efficient ways of drawing a family or group of friends together.

Which I guess is why, despite Camembert, foie gras, and pain au chocolat, the French outlive the Spanish by a mean of seven months and the British by a full two years. It’s also why, despite robust evidence that I’m stacking up an adverse risk profile, I’ve reinstated the coconut milk and ghee on the weekly shopping list.

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The benefits of gout

In the 18th century, people of the middling sort would spend their evenings reading magazines of miscellaneous content by candlelight. One such was *The New Universal Magazine, or Gentleman and Lady's Polite Instructor In every Subject that is Proper to display Nature; to promote Virtue; to help agreeable Conversations; and to form the Judgment in the several Stages, Degrees, Offices and Stations of Life, the whole intended to restore the declining State of magazines by a Constant Supply of true Knowledge and Pleasure.*

Volume 3, of 1753, contains a fair bit of medical information, for example how to prepare snuff for swimmings of the head and how the Chinese prepare a dust of dried smallpox pustules to be inhaled by children—for, as everyone knows, the poison of the adder taken by inhalation is not nearly so dangerous as when it is inserted into the flesh, as with the British way of smallpox inoculation.

There is also an article on the benefits of gout. These are two. The first is that an attack of gout is like whipping, being nice when it stops, and therefore makes you appreciate your health and good fortune in a way that you never did before: “How often have we heard a grave adviser, one that has tried sickness and health alternately, for many years, tell a young robust riotous fellow, that he knew not the value of health, having never been sick. But I'll warrant him by the time he has got the Gout, he'll thoroughly understand the matter.”

The gout sufferer will learn to appreciate life: “O! so easy, so pleased, so joyous, so happy, so blessed will you be when the turn of health shall come. Why, Sir, you'll be in heaven; in heaven while you are upon earth.”

BETWEEN
THE LINES
Theodore Dalrymple

The anonymous author prefers “plain cathartic gruel, and cataplasms of fresh cow-turd”

Since gout does not lead to death, it is not a real disease; and the view that it is a disease has been assiduously promoted by doctors to drum up business for themselves: “The physician, purely to force a trade, imposed upon the people, that the Gout was disease; and having cheated them with this false opinion, he plagued 'em with real tortures, in a way he was pleased to call the therapeutic method: in which his barbarous executions thus follows one another: first phlebotomy; then catharticks, emetics, hypnoticks: and while the inside of the poor patient is thus miserably racked and confounded, he daubs the outside with anodyne applications, unguents and cataplasms.”

To all of which the anonymous author prefers “plain cathartic gruel, and cataplasms of fresh cow-turd.”

The other great advantage of gout is that it predicts the weather, getting much worse before storms. It is far more accurate as a weather forecaster than the barometers of the day. Indeed, “if the fortunate patient would be at pains to observe all the motions of the Gout in his pinching, smarting, galling accesses and in his gnawing, stabbing, burning paroxysms,” then he will predict forthcoming storms to perfection.

“In a short time no owners would think their ship safe, but with a gouty master; nor would any experienced seaman, wanting a ship, offer himself to the merchants, but upon crutches.”

So all is for the best in this, the best of all possible worlds. Voltaire's *Candide* was written three years after this eulogy to gout.

Theodore Dalrymple is a writer and retired doctor
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MEDICAL CLASSICS

Essays on the First Hundred Years of Anaesthesia

By W Stanley Sykes

First volume published 1960

In many departments where I have worked there is a shelf in the library that contains old, dusty books about the history of anaesthesia. Browsing one day, I picked up one old book and found I could not put it down.

Born in 1894, William Stanley Sykes was an anaesthetist in Leeds before the second world war. He was captured and held as a prisoner of war in Greece for some years. At the end of the war he returned to civilian life to find that anaesthesia had evolved in the intervening years, and he considered his skills to be obsolete. He decided to retire and devote his life to the study of anaesthetic history and equipment.

The result was a collection of essays of enormous erudition. The topics were discursive and seemed to be random; but by deviating from the well trodden paths of the history texts Sykes gave us a fresh angle. The essays include a brief account of his own experience as an anaesthetist in a prison camp and some astonishing case histories, such as David Livingstone's own account of his mauling by a lion.

Sykes ferreted out many original documents and sources in his endeavours to set straight the historical record. He showed that chloroform was used as an

Sykes was unrelenting in his condemnation of what he saw as inefficiency, stupidity, and ignorance

anaesthetic six months before James Young Simpson used it on his dinner guests and that the word “anaesthesia” appeared in print over a year before Oliver Wendell Holmes thought he invented it. He told us about many failed ideas and dead ends: neither rectal ether nor subcutaneous

oxygen made it widely into practice, although curare managed it after a somewhat shaky start.

Sykes was unrelenting in his condemnation of what he saw as inefficiency, stupidity, and ignorance. About one particular dangerous looking device he wrote: “It is not stated how long this machine was in use before it blew up.” In another chapter he asks in exasperation: “Is there any device in the whole of anaesthesia which has not killed somebody?” But where he found excellence Sykes was quick to praise. Of Joseph Lister he wrote: “He did not gain his position of unchallenged pre-eminence by making piddling little improvements. Instead he completely remodelled the whole of operative surgery and changed it from a crude and dangerous handicraft into an expanding and much safer science.”

The first volume of essays was published in 1960. A second came shortly after Sykes's sudden death in 1961. Some unpublished material was collected into a third volume by Dr Richard Ellis and published in 1982. Sykes's unusual approach, scholarly excellence, and uncompromising forthrightness of tone make his essays a stimulating and enjoyable read. You might even find a copy beneath the dust in your own anaesthetic library. Aidan O'Donnell, consultant anaesthetist, St John's Hospital, Livingston, West Lothian aidanmark@doctors.org.uk

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