Vive la révolution

FROM THE FRONTLINE
Des Spence

In the howling darkness of the remote croft in Orkney that was my childhood home the television flickered with enticing images: Levi’s jeans, “roller boots,” bubble gum, *Dallas*, Burt Reynolds moustaches, purple nylon flares, the Osmonds’ teeth, *Champion the Wonder Horse*, foot long hotdogs, giant lawn mowers that you sat on, and supersized burgers, at a time when half a pound of mince would feed our family for a fortnight. This was paradise America. Even their chips were exotic, crispy “French fries,” not a mush of lard and yesterday’s newspaper.

The Americans had saved Europe twice, smooched all the girls, given us Elvis, landed on the moon; and not only all that, they had tackled racism head on and liberated people from conventional roles of gender and sexuality. The United States was an all conquering and fearless pioneer of meritocracy. In the 1970s where the US led we Europeans would follow. It wasn’t that I just admired America—I wanted to be an American.

But times change. Now America offers a voyeuristic spectacle of excess and extremes. And when I regard our friends across the Atlantic I worry greatly about their medicine: the lack of universal coverage, the absence of a notion of collective public health, chasms in access to care. However, it is the obsession with “interventions,” be they surgical, radiological, or, most often, pharmaceutical, that is most disturbing. Despite the trillions of dollars it spends on health care, the US is perhaps the unhealthiest nation in the developed world.

Recently the American Pediatric Society endorsed the use of statins in children (*BMJ* 2008;337:a813; *BMJ* 2008;337:a886). From a European perspective it seems not just implausible but more: it is simply wrong. There are no trials of statins to prevent vascular events in children. Thus children will be submitted to powerful drug treatment during a key period of their development in the absence of any knowledge of long term safety. This is regrettable but is just one example of the US medical profession’s intrusion into childhood, robbing the young of the chance to enjoy their feeling of invincibility.

I have the deepest respect for the American doctors I have met, but the US obsession with freedom is medical lawlessness. Anything goes. You can blame the selfishness and hauteur of the “royalty” of the capitalist medical world—the drug companies—but that would be unfair. For the medical mobility—the professions and societies—have supported this decadent regime. It is now time for America to look across the Atlantic, to don a beret, light a cigarette, and get on its bike—and time for the proletariat, we doctors, to storm the medical Bastille in the name of “ liberté, égalité, fraternité.”

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Old whines and new battles

“*I’m sorry, Mr Jones, but would you mind coming into the patient advice and liaison office?*” says the nice woman in the spectacles. “You see, the doctor’s complained about you,” she adds in a slightly gentler tone.

“It seems that he’s not happy about what happened yesterday when you told him to eegghum”—she clears her throat—“off in the waiting room after he refused to prescribe you sleeping tablets.

“We have a trust policy on this: you have to respond within 14 days. We suggest a letter of apology—that should do the trick. Most of the upset doctors seem to respond very well to this. I can help you draft it if you like.”

If only this were true. It’s funny, isn’t it: patients can complain about all manner of things—from the downstairs frivolous to the serious—and be assured of a swift and contrite response, yet the same privilege is not afforded to staff who are genuinely trying to help patients.

“I don’t know of many doctors who have defecated, urinated, attempted to hit someone else, or used expletives in front of sick people in the hospital. But we see patients who do these things unapologetically on a daily basis and let it slip by as if these sorts of behaviours are expected, as if they ought not to know better.

Of course, we, like other hospitals, have a rather cumbersome “red card policy” of several thousand words, which includes helpful steps such as asking the person to desist: “Please stop urinating in the corridor, sir.” But it has no mention of asking the patient to show any regret for their actions. And the most serious sanction seems to be shipping the patient to another hospital, where they can cause the same problems.

Besides this, use of the policy often results in even more issues to deal with and paperwork. One of our consultants was once asked by the chief executive to respond formally to a complaint a patient had made. The consultant in question had excluded the patient after he had walked out of a clinic room shouting to the waiting room, “I didn’t ask to see a fucking black lesbian.” Evidently, it was not considered sufficient that the facts of the case spoke for themselves.

Maybe it is time for a Giuliani-style crackdown on behaviours that traditionally the NHS has ignored. Perhaps this will engender more of a feeling that hospitals are places where the sick go to be treated for free rather than a successful conclusion to a Friday night out.

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Lay your money down

I was born in Essex. But I have spent my life in Scotland, a place where sometimes it’s not easy being English. I still have an English accent and a pathological urge to say “please” and “thank you.” But this is a mere veneer, for I have gone native—my heart is tartan. I am the Hollywood stereotype, a heathen, war painted, kilted transvestite, stubbornly holding my ground no matter what, and am therefore direct and blunt. If this upsets people, so be it. So when the BMA and academics hail the benefits of the clinical elements of the quality and outcomes framework (QOF), I say I do not believe them.

In a Celtic sceptical tradition, I voted against the new contract, believing that it would jeopardise the care of patients. For long ago I lost faith in fables of medical economists’ cost benefit analysis, a science so riddled with confounding falsehoods as to be little more than pagan incantations. This is now the fourth year of the contract—and four years since any doctor looked properly at the patient, obsessed instead by their computer screens and chasing the points. The government shelled out payments, making us richer, unhappier, and unpopular. And to what clinical benefit?

We have had a fanfare of studies reporting minor improvements in glycated haemoglobin, blood pressure, cholesterol—just soft surrogate markers of disease. Indeed some reports go further, suggesting a narrowing of health inequalities. But in the inner cities these are illegitimate markers of inequality; our real medical demons are the unholy trinity of alcohol, drugs, and violence, combined with the poverty of expectation. Has there been a national change in the gradient of decline in the hard end point of vascular related deaths? Have we seen a large reduction in complications of diabetes or chronic obstructive pulmonary disease? With such a highly powered public health experiment and enrolment of so many unconsenting volunteers, surely after four years we should have some hard data.

It is not just the huge financial opportunity cost, nor the well made unwell, but the wanton consumption of our medical energies that I take issue with. Our energy has been spent bean counting the measurable while dismissing the most valuable aspect of medical care, the immeasurable. Perhaps I am wrong. But I will stand my ground of absolute scepticism until some redcoat finds real evidence to run through my Jacobean heart.

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Alma-Ata no more

Almaty, capital of Kazakhstan until 1998 and the country’s largest city, is about seven hours from Heathrow: a meal, two in-flight movies, and a snack. It lies in a beautiful setting beside mountains on the country’s southern border. Until 1993 it was called Alma-Ata, a Russian mistranslation meaning “father of apples.”

Sitting there last week, I wondered whether the big sanatorium that housed our WHO meeting had been the scene of the Alma-Ata Declaration 30 years ago, something I remembered only vaguely but that has almost religious significance in the world of public health. A few minutes’ googling disabused me.

In 1978 the first International Conference on Primary Health Care was held in a vast 3000 seat hall beside a specially built hotel. The representatives from 134 countries included Senator Edward Kennedy. The show was funded by the Soviet Union, keen to beat China onto the world stage. China stayed away.

The hotel is still there, the tallest building in Almaty. Primary care, however, has survived the fall of communism less well. Here, as in many post-Soviet countries, non-medical people use a familiar phrase when they grumble about rural health care: “You can say what you like about the communist era but …”

The Alma-Ata conference (“Health for all people of the world by the year 2000”) was medicine’s equivalent of the Woodstock festival, and its anniversary has inspired nostalgia among medical ex-hippies: “Yeah, man, there’s been some, like, slippage. But, hey, we can still get there. Stay cool. Gather more data.”

For us non-hippies it’s hard to be cool. We ask ourselves why we go abroad with cash strapped organisations, offering sticking plaster to cover gaps in other people’s healthcare systems. International aid budgets are laughably small, but non-governmental organisations have got used to them. You suspect that they quite enjoy being short of money. Mother Teresa and all that.

The sanatorium, formerly a health farm for the party elite, has a magnificent inner dining room. Every mealtime each table has a notice with the name of an international organisation. The tables don’t talk to one another, partly because of uncertainty about which language to use and partly because that’s not what aid agencies do. Cooperation would smack of big business, which demands results. International aid, although it talks big, prefers to be a cottage industry.

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The tablets of stone

Sniggering came from the rows behind me. I smiled too. “Rubbish,” my inner voice jeered. This was my tutorial group’s meeting on the role of the general practitioner in the consultation. No cardigan wearing, bearded, Jethro Tull groupie could convince me of the pagan effect of “the placebo,” nor that doctors were somehow druids empowered with a “therapeutic effect.” (The Hungarian psychologist Balint coined the term “drug doctor” to describe this.) Fresh from the hospitals, I was a disease search and destroy droid. I would not believe in these dark arts and stopped listening. But I have forgiven the young their arrogance and stupidity, for research has now established the therapeutic effect of doctors and placebos.

Science is but a small part of medicine, with “illness” often having little to do with actual illness. Many symptoms are unexplained (and unexplainable), and culture and conditioned health seeking behaviour are the major determinants of patients’ use of health care. We live in a society that actively incentivises the sick role, with 2.6 million people on incapacity benefit and corporations busy inventing social illnesses and then using disease aware “education” campaigns to drive up demand and supply. So, despite historically being at our healthiest, we have never felt more ill.

Therefore witness the artistry of the sage doctor seeing a patient infected with this medical anxiety. The laying on of hands, the power of distraction (perhaps a quip or a question about family)—all this while emitting a force field of reassurance that you can almost touch. It is never the “clever” doctors that patients wait to see but the kind ones. Likewise, the occasional cough medicine or vitamin, though long since proved ineffective, can have a dramatic effect if sold with style (even if administered with the caveat that it might not work). Indeed, such clinical effects are the basis of all complementary therapies but are no less worthy for that.

So, in this time of a rapidly rising prevalence of illness but a steep decline in disease, amid this storm of medicalisation and the vast gathering swell of sickness behaviour, we need the skills of the “drug doctors” and the option to use “placebos,” as increasingly the most important intervention is nothing at all. These concepts need to be a priority in teaching at undergraduate and postgraduate level, for the future wellbeing of society is no sniggering matter.

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See PERSONAL VIEW p 579

The nano state

The Society for Social Studies of Science—4S—is a group of sociologists who study scientists and the social effects of their research. Last week I was lost in their vast international conference, which focused on medicine, health care, and technology.

I tried to get into a presentation entitled “My internet penis: male panics and the queering of penis enlargement emails,” but there had been queues since dawn, and there was standing room only. Apparently some 6000 men every month hit the reply button and say, yes please, two more inches. Could someone in this thriving research community please find out why nobody sends me emails offering to deepen my vagina by the same amount?

The big theme for 4S is nanotechnology. Focus group research has, apparently, proved that most of us have no idea what the word means. “Nanotechnologies” are materials that have been designed at the tiniest microscopic level, mainly by manipulating very small, curly bits of carbon. They have fantastic properties—for example, combining ultra-light and ultra-strong; being ultra-superconducting; or embedding powerful catalysts within their fabric. All this makes for decades of fun producing futuristic inventions such as odour free underwear; the smart brick; a mug that removes the bubbles from your cola; or a machine that can etch a three dimensional Elvis on your gravestone. And socially useful innovations such as systems for delivering magic bullet drugs; a new generation of remote patient monitoring; and micron by micron total body scanners.

The hot issue with the nanotech business—at least, according to the doom and gloom presenters in Rotterdam last week—is unknown health hazards, made more perilous by the recent expansion of an unregulated industry in an intellectual property gold rush. All of which is compounded by government obsession with economic growth and the diversion of public outrage into scientific non-scandals such as genetically modified crops and secondary uses of patient data for research.

What health hazards? What indeed. When you wash your odour free undies, the nanotech molecules—which are as indestructible as diamonds—will start digesting your washing machine, and then your pipes, and then the critters at the bottom of the ocean. Or at least no one has yet proved that this can’t happen.

Solutions? Don’t be silly: it was a sociology conference. But maybe some of us should make it our business to shift from blissful ignorance to critical questioning.

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The rubber ear

The male lead singers of US rock bands of the 1980s—with their frizzy, long blond hair and pink make-up—were the prettiest girls on television. Their screaming guitar solos and the wailing backing vocals were a rock abomination, although the greatest danger lay in listening to their lyrics. Listening, however, is the doctor’s mantra. I have spent the past decade teaching undergraduates how to listen. I have suffered the tantrums of medical school actors who clearly resented the bit part of “a middle aged man presenting with chest pain,” and I have gritted my teeth during the feedback sessions. The final insult has always been the ridicule of colleagues who exclaim: “You TEACH communication skills?”

As a postgraduate trainer I pretend to have read all the worthy but tedious books on conducting a consultation. I struggle to stay awake during a thousand video feedback sessions. I am bilingual in the pseudoscientific babble of communication. Whatever the setting, I emphasise the importance of listening to patients. But should I?

My medical Alan Sugar (worshipped by patients and colleagues alike) once told me, “Dear boy, don’t actually listen to the patients—just look like you are listening.” And of course he was right. I spend most of my time actively not responding to patients’ cues or listening. I engage in the art of distraction and misdirection, getting them off the medical topic by making mental notes of hobbies, football teams, and family.

For most of GPs’ time is now spent on an increasing number of patients with primary care season tickets, standing in the terraces of waiting rooms, week in, week out, rain or shine. Since we cleared the slums and fed and vaccinated the children, real illness has plummeted. The medical model is now largely defunct and has been replaced by aberrant health seeking behaviour, encouraged by ill conceived disease awareness campaigns and disproportionate media coverage of celebrity illness. The victims—the worried well—duly attend with healthcare clippets directly from the medical pages of gossip magazines. If we doctors responded to all the cues, most people would be in hospital for investigation most of the time.

I always try to deal with patients’ concerns by listening to the soft rock music of their lives. But much of the time, for the sake of their health, I ignore the lyrics. I am not sure that the communication authorities, however, are ready to hear this.

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Campaign for real lectures

I recently decided that I had been on the receiving end of death by PowerPoint one too many times. I have probably also dished out my share of wordy, overly structured lists of bullet points to glazed, uninterested audiences. So I’m starting the campaign for real lectures.

Last month someone bet that I couldn’t talk for 45 minutes on the state of primary health care in the world using only slides of pictorial images. I gave my lecture last week, and we’re still arguing about who won the bet (which rests on whether I was allowed to use text in my summary slide). That apart, I think I pulled it off. I read from a typed script (written in full paragraphs) and linked each theme to an image (or three). In total I showed 94 photographs, five diagrams, three pieces of abstract art, two maps, and a graph. Afterwards, someone said “that must have taken you ages,” and I admitted that it had. But nobody (even someone’s accompanying 6 year old) seemed to be bored.

People rarely go to lectures to learn facts. They go to be inspired, to discover what’s new in the field, and to be challenged to think differently. The success of a lecture should therefore surely be measured not by how much more people’s knowledge has grown but by how much their framing of the topic (and the extent to which they care about it) has shifted. Images generally achieve this better than words. Yet although I have been on several PowerPoint courses that covered font size, arrangement of text, and so on I have never had—or been offered—training in the use of visual images.

I’m still a novice at real lectures, but here’s a tip that saved my hide last week: make use of royalty free images (use Google). There are hundreds of thousands of them in internet image banks. Each image has usually been uploaded by a private seller, who has already made sure that the file is large enough to project crisply, has optimised the colour and tone, and has gained informed consent from the subject. The seller collects a small sum (typically less than £5) whenever anyone downloads that image. You can search the image banks with keyword terms (“domestic violence,” “children in Mongolia”) and store a shortlist for later browsing. You can also reuse the images as often as you like.

I had planned to keep this idea to myself, so that the applause for my lectures was louder than that for yours—but since I listen to more lectures than I give, it’s in my interest to share it. Join the campaign!

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The world is round

“The JVP is a unicorn—a myth.” All eyes turned to me. I knew it was mistake, a heinous blasphemy. There then followed an unholy medical inquisition. Despite my heresy I still religiously teach students how to test for jugular venous pressure, but when I suggest that it may be of highly limited value their eyes narrow suspiciously. For the JVP test is part of the holy scripture passed down through generations of doctors: the clinical examination.

But much of clinical examination is ritualistic ceremony—mere incense and incantation. Even the iconic stethoscope is really a redundant artefact, a medical prop. Yet cardiologists, with their cardiology stethoscopes, continue to tut and to lambast students on the character and timing of inaudible murmurs, even in the full knowledge of the echocardiogram report. Much clinical examination has remained largely unquestioned through the mists of time and is deployed to uphold a mystical faith in the higher orders.

Clinical examination is just another type of investigation and screening. The problem is that doctors are prone to learn and apply clinical medicine in an absolute way, leading to either false reassurance or, more often, unnecessary investigation and anxiety. Today when we introduce new investigations they are subject to close scrutiny: we want to know the positive and negative predictive values, the specificity and sensitivity, and the rest.

My criticisms may seem dangerous and offensive nonsense, and doctors will argue that we need such clinical skills, for one day we may find ourselves working again in an environment without investigative facilities. But if this were the case then it seems highly unlikely that there would be any treatment facilities anyway. And this still doesn’t address the issues of sensitivity and specificity.

Is it time to sacrifice the sacred cow of clinical examination? Yes and no. There is no doubt that some clinical signs (such as abdominal tenderness) are very useful. But we need to apply scientific rigour and expose the limitations of clinical examination. Keep the useful stuff, and ditch the dangerous, insensitive, and nonspecific mumbo jumbo. We need to teach students to focus on the red flag signs and tune in to disturbances in the normal pattern of clinical presentation that act as subtle clues to illness. And in teaching students we should dedicate our energy to the use of appropriate and proportionate investigations. If I am to be excommunicated—so be it.

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Freedom

I worry about lots of things these days—my career, my pension, my elderly mother, how my children are doing at school (very well so far . . . but who knows?), road crashes, passive smoking, wrinkles, medical autonomy, insane world politics, global warming.

While I worry a lot, there are some things that I do not need to worry about. I do not need to work for the minimum wage. I do not need to work for less than the minimum wage. I have more than one legal passport and do not need to cross borders stuck in a container. I own my own house in my own name; I do not have to raise my children on a rubbish dump. Even if I hit a financial bad patch I will not need to go on the streets to feed my children (medicine pays more). No one can sell me.

My water is clean and comes from a tap in my house; I have a full fridge. I know enough about health care to get the right treatment. I have international health insurance when abroad and the United Kingdom will offer me enough health services to survive a catastrophic illness and not bankrupt me. I can see, hear, and move around without wheels or aids, so no gathering, concert, or building is out of my reach. I have been educated in the best schools and universities and reached the rank of professor, so if anyone discriminates against me I can at least snub them back and at best take expansively successful legal action.

Another pregnancy is not likely to kill me; I am well fed and close to excellent obstetric services, so I will never face an intended four day obstructed labour, have a dead baby extracted, and then live in the twilight zone of a rectal fistula. My husband or my in-laws will never arrange for my pre-teenage daughter to have her external genitalia cut off, be sold to a trafficker to pay off a gambling debt, or married to an elderly rich landowner.

I have my own bank account and there is money in it that I control; I can get credit. I kept my own name after marriage because I wanted to. I can read, I can speak my mind, I can vote, I can drive a car to work. I can go out at night with my friends. I can wear makeup. I can wear anything I like. That short skirt may look better on someone younger or thinner, but no one can stick me in prison for wearing it.

Yes, I may be worried these days. But I am pretty free, while so many women and girls in this world are not. Just when can they have worries like mine?

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Spam medicine

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, flaying 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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Anyone for Club Med?

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. Hmm. 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 cardamon. 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 about 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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Doublespeak


Gone are the comments that spurred a generation. Our coffee stained report cards were at least honest. “Desmond would do much better if he occasionally listened.” “Desmond’s English would improve if he learnt to spell and occasionally used something we call punctuation.” “Please provide Desmond with a gag next term.” “Desmond is a clumsy boy.” But now there is nothing worth hanging in your downstairs toilet to entertain your guests. Why has our society become so fake and lost the ability to be honest?

Many professional groups have suffered a succession of high profile inquiries, berated for perceived failings and accused of a catalogue of institutional “isms.” The reaction of service directors has been to make their organisations ever more risk averse. But by introducing increasingly restrictive protocols, institutions are eroding the core values of professionalism: discretion and judgment. In turn power has shifted away from the professional to the client, the patient, the pupil, and even the pet. Some changes were of course overdue, much of the criticism justified—but we have gone too far. We have created a complaint economy with a hyperinflation in skewed and stupid feedback questionnaires and wads of bankrupt unrepresentative users groups.

We doctors are now so fearful of criticism and complaints that we are no longer able to be honest in consultations, assessments, reports, or referrals. This makes our job increasingly difficult. Being patient centred is important, but we struggle to challenge (even sensitively) people’s lifestyles, parenting skills, behaviour—resulting in ever increasing medicalisation. In removing a sense of personal responsibility our society is in danger of decapitating our moral selves, leaving just a flailing corpse of entitlement, bleeding out the last of our self esteem.

Medicine isn’t just another service industry, and the customer isn’t always right. We don’t need to return to the paternalism of the past, but for the sake of our patients we need to be able to be open and honest without the threat of unfounded complaints. We have the ability, but it may be too late; we should have done our homework, worked harder, and applied ourselves.

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Benchmarking the turf

Many years ago, a small child was dropped to play at our house by a very snobby grandmother. As she left, she asked, “You’re not going to take him across to that park, are you? I’d be happier if you kept him indoors. You see, this isn’t what I would call a ‘good area’.”

It was true. The entire street was (at the time) occupied by teachers, nurses, academics, and even—perish the thought—a police officer and his wife. We sent our kids to the local state schools, and got our health care on the NHS. The only church within walking distance was Methodist; the synagogue was “reformed”; and both were overshadowed by the splendid local mosque. I could well see why my visitor wanted the infant prince protected from all this.

The area has moved on considerably, as London’s house prices have outstripped even private sector salaries. Our neighbours now include merchant bankers, commercial lawyers, and someone with a (secondhand) Porsche. But is it actually a “better area”? And how would you benchmark yours?

If ego surfing is looking for references to oneself on Google, then we need a term for the practice of seeking objective indicators of the worth of one’s locality. In the old days “deprivation” (and whatever you choose to call its opposite) were measured crudely, by assessing (for example) average number of occupants per room, access to a car, or the proportion of children receiving free school meals.

These days, neighbourhood snobbery has become a sophisticated science, with a wealth of comparative indicators downloadable from the internet. Take a look at www.communityhealthprofiles.info, for example. The next time your daughter says she’s got a new boyfriend who lives in OtherBorough, you’ll be able to check out whether to allow her to visit him on public transport, under armed guard, or not at all.

My own patch scores a smidgeon better than the UK average for most indicators (proportion of children living in poverty, obesity levels) but does much better on some (teenage pregnancy, binge drinking, sick days due to a mental health problem) and worse on others (ecological footprint, tooth decay). If I stay here, I can expect to live 19 months longer than the average female citizen, and I’m only half as likely to get run over or mugged as someone in Birmingham. All of which adds up to an evidence based ditty: “Girls and boys come out to play, whatever Oliver’s Gran may say.”

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The treatment paradox

He sat in a crisp, double breastsed, pin striped suit, nursing a leather FiloFax and flipping through the glossy charts showing pension growth. I nodded confidently to cover my bewilderment at his sales pitch. Twenty minutes later he crushed my hand and left, with my signature on a monthly investment. Five years later I scratched my now shaved head in bewilderment at the evaluation quote of £67. I complained about mis-selling to the financial ombudsman and vowed never to be fooled or confused by an “expert” or numbers again.

Whether it’s worth treating high cholesterol is a common enough question. No one who sees the charts and listens to the sales pitch would doubt it—but numbers are open to being spun. Let’s consider the trial known as WOSCOPS—the west of Scotland coronary prevention study (New England Journal of Medicine 1995;333:1301-8). It wasn’t by chance that the west of Scotland was chosen. The participants were men aged between 45 and 64 in the most socially deprived area in western Europe. More than three quarters (78%) were current or former smokers, and their average cholesterol concentration was 7 mmol/l. If lowering of cholesterol concentration was going to work anywhere it was going to work here. The study ran for five years, and the researchers reported a 32% reduction in cardiovascular mortality in the group of men who took statins. (Similar reductions were seen in all vascular events, but death is the irrefutable end point whose delay is most of interest to patients.) Other studies have replicated similar results, and so the pandemic of “cholesterol” swept the world.

But the numbers can be presented in another way. Converting the 32% relative risk reduction into an absolute reduction gives a derisory 0.7% reduction in cardiovascular mortality and a number needed to treat of 143 over the study period. Although it may be cheating, this figure can be annualised to give 715 to prevent one vascular death. So, putting it crudely, some 714 patients a year gain no benefit from treatment, even in the highest risk population in the world. With persistent disease creeping into younger and lower risk groups, along with a background decline in the prevalence of ischaemic heart disease, these numbers are likely to be higher.

This is the “treatment paradox”: that an individual patient, despite many years of investment in taking statins, gets virtually nil health benefit. Any relative benefit is seen only at the population level, even for composite cardiovascular end points. The treatment paradox is true of all treatable risk factors such as hypertension and osteoporosis. Patients might rightly scratch their heads and complain about mis-selling if the numbers were presented in this way. But trust me, I am no expert.

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Development lesson

I was waiting on a dusty street corner in one of Africa’s poorest countries, with six teenagers. To pass the time, I invited them to give me 10 differences between “third world” and “first world” countries.

“Easy,” said one. “We’re doing this in Geography. GDP.”

“Okay, so people don’t earn much. What’s the impact of that?”

They surveyed the rows of stinking slums. “People can’t afford nice houses. No kitchens or bathrooms. And the roofs sometimes fall off.”

“Why do you think they don’t earn enough money to buy nice houses?”

“I think they might not be able to read. And there probably aren’t enough jobs to go round.”

“Why not?”

Silence while they contemplated where jobs come from.

“Well, they can’t work on a farm because there’re no farms. Nothing grows here.”

This was true. The country was built on rock.

“And no factories either. All the goods are imported.”

“You could build a business, like those call centres in India. But I guess they don’t know how.”

We were observing a man arc welding pipes in the middle of the pavement, surrounded by hordes of barefoot children. Car horns drowned the imam’s chant from the nearby mosque.

“They don’t seem to care about safety. Everyone drives really crazy.” We recalled the limbless beggars and the little boy with the missing eye.

“What about health?” I asked.

“I think they would get diseases probably congenital. One final question: “Right, you clever kids, how would you solve all these problems?”

Eventually one of them ventured a solution. “I think,” she said tentatively, “I would start by building a school.”

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Ladas and MOTs

Ike Iheanacho

FROM THE FRONTLINE
Des Spence

I once owned a Soviet Lada Riva. The mats didn’t fit, it skidded at 10 mph going round corners, and, for a car built for the Siberian wastes, it never started in the cold. One day an engine fire blazed my Lada to Valhalla, despite regular servicing and an MOT test. I was glad.

Gordon Brown, our new politburo boss, has promised a revolution of American-style screening “check ups” (BMJ 2008;336:62-3). Should we recalcitrant general practitioners resist this centralised diktat, then private sector workers are on standby to be bused across our picket lines. For screening is a simply a good idea, isn’t it? The popular media have long bemoaned the lack of screening in the United Kingdom. So, seduced by this populist health initiative, Mr Brown has seized the headlines.

Unfortunately, people aren’t cars. Screening is based on a number of established criteria: specificity, sensitivity, acceptability, reliability, and, above all, that early diagnosis makes some difference to outcome. The screening announced by Gordon Brown for diabetes, aneurysms, kidney disease, and the rest simply does not meet these criteria. Even for established screening programmes, the benefits over risks are contested. Consider cervical cancer as an example: it is necessary to screen 1000 women for 35 years to prevent one death—which means, therefore, that 999 women will receive no benefit from screening. Worse, some 40% may have a positive smear and 5% may have needless invasive treatment (BMJ 2003;326:901). Screening is not the simple, one way street of benefit that the media suggested, but an anarchic highway full of dangerous machinery and meandering livestock. The only certainties of screening are uncertainty and anxiety.

The inverse care effect will, as ever, see the predictable, miserable lines of low risk, worried well clogging up NHS services. The high risk, unworried sick will continue happily to ignore our screening initiatives.

MOT “check-ups” are stupid and nothing but a medical charade. If Mr Brown is serious about improving health, might I suggest some public health medicine: limit personal car use, build cycle paths, tax processed food, subsidise fresh foods, and re-establish a food culture. The mats don’t fit on these plans, which will spin off at the first corner, burst into flames (I hope), and go to hell.

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Paying for the view

It’s a wonder they can talk at all, given their mouths are so stuffed with industry gold. Somehow, though, they manage it, and often to great effect.

Opinion leaders are megastars of the medical world. Groomed, pampered, and promoted by drug companies, they are the role models whose views are to be taken seriously.

Such individuals are part of an elaborate game that supposedly ensures “transparency” about the relationships between doctors and their industry paymasters. The declarations of competing interests so beloved by journal editors, academic boards, and advisory bodies are a key part of this charade. And then there are the statements about potential conflicts made at conferences and other meetings, and the ostentatious offers to leave the room when a personal interest might unduly sway a discussion.

These rituals are all well and good but are at best a sop and at worst represent a cover-up. For example, monetary value of industry’s sweeteners for opinion leaders is often missing from even the most florid “declarations.” What’s more, the game carefully excludes patients and the wider population—the people who really deserve to know who might be pulling a doctor’s strings.

The excuses routinely trotted out to avoid such exposure are risible. “None of these personal interests affects my clinical judgment” (How would you know?). “Patients have no interest in or understanding of the issues involved” (How would you know?). “Scrutiny by my peers is more than enough” (Who are you kidding?). “I have relationships with several companies and this ensures I’m unbiased” (Have you heard yourself?). It is time to do away with these poor evasions.

Achieving this will be difficult and requires radical solutions. One such solution would involve taking a lead from another group of stars.

Through the badges and logos on their livery and cars, grand prix drivers offer clear public messages about their commercial ties and allegiances. Similarly, doctors with personal drug company interests should be expected to have these emblazoned prominently on their clothes, so giving their patients and, indeed, other healthcare professionals valuable insights.

Presented with such graphical information, some patients won’t notice or be bothered that their doctor is being rewarded by drug companies. Others might interpret this as confirmation of a professional’s expertise and standing. But, crucially, all would be better placed to consider treatment advice in context.

Anyway, if opinion leaders insist on being talking billboards for the industry, they might as well look the part.

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Everyone hurts

My head lolled, and the ash from my cigarette flicked onto the carpet tiles of the hospital’s doctors’ room. My energy and enthusiasm were sucked grey and frail and were about to crumble into dust. This wasn’t what I had signed up for. There was no induction course, just “see one, do one, teach one.” Mistakes were endemic. The names on the forms were wrong, wrong investigations were ordered, wrong drugs were prescribed, wrong fluids were written up, the wrong procedures were done. Sociopathic seniors appeared at random. The once coveted pager was now the bleeping instrument of my insanity. The zip of the curtain at death was a release for all concerned. All residents were drowning in an ocean of inexperience. We were supposed to care, but caring didn’t seem possible; we were sustained only by the darkest humour and a vital camaraderie. But the worst thing was my lack of control and my collusion in the depersonalised medical processing plant. Like everyone, I felt like leaving.

This February many foundation doctors will feel the same way. What does this spoilt generation have to complain about? Shorter hours, better pay, induction courses, mentoring, supervision—they’ve never had it so good. But such an attitude is merely the foolishness of the old. Everyone hurts and doctors rely on standard US textbooks. Dollars (in cash) are the currency for visitors. Television has endless Hollywood movies. Yes, CNN was jammed, at least in my hotel, but there’s still the radio, where the Voice of America competes successfully with the BBC.

Having missed the news from Baghdad of the press conference shoe attack, I was surprised to see a chuckling television reporter organising a shoe throwing competition in the street. One almost hit an elderly, burkha clad woman. The crew rushed over to apologise, saying they had mistaken her for President Bush. She laughed and laughed.

The three wise men came from these parts, but Iran’s history of learning goes back long before that. These days the country’s reorganised primary care system has to cope with a couple of million refugees from its eastern and western neighbours. The local obstetricians, all women, murmur unhappily about the fate awaiting Afghan baby girls once they are taken back home.

Near the end of my stay an explosion went off outside my window. My first thought was that this must be the latest manifestation of Western foreign policy. It turned out to be fireworks celebrating the Eid al Adha festival. Sipping orange juice and watching starbursts on the skyline, I felt as if I were back in Leeds, on call on millennium night.

It was snowing when I left for Tehran in December, your colleagues look worried. This means someone else playing Santa at the Christmas party. And Iran has an image problem. No one actually says “axis of evil,” but everyone thinks hostages, and some actually says “axis of evil,” but has an image problem. No one at the Christmas party. And Iran means someone else playing Santa colleagues look worried. This to Tehran in December, your When you say you’re going fireworks in Iran _Everyone hurts_.

Fireworks in Iran

When you say you’re going to Tehran in December, your colleagues look worried. This means someone else playing Santa at the Christmas party. And Iran has an image problem. No one actually says “axis of evil,” but everyone thinks hostages, and some people just don’t like the name. Why can’t it still be called Persia? people just don’t like the name. everyone thinks hostages, and some actually says “axis of evil,” but has an image problem. No one at the Christmas party. And Iran means someone else playing Santa colleagues look worried. This to Tehran in December, your When you say you’re going fireworks in Iran