



## A few bad apples

**Operating in the dark:  
the accountability crisis in Canada's health care system**

Lisa Priest

Doubleday Canada, Toronto; 1998

318 pp. \$34.95. ISBN 0-385-25719-8



Should hospitals be rated? Which is more important, a physician's right to privacy or patient safety? Are hospitals too soft on surgeons? Should we set "volume" standards on surgeons, as the airline industry does on pilots? Should the sickest patients be treated the soonest? Should it be easier for hospitals to fire doctors whose skills are slipping? These are some of the questions that journalist Lisa Priest confronts in *Operating in the Dark*. Nothing in this book will come as much of a surprise to regular readers of *CMAJ*. The issues it raises include the problems at the pediatric cardiac unit at the Winnipeg Health Sciences Centre, hospital report cards, competency training for physicians, waiting lists, the story of laparoscopic cholecystectomies, variations in procedure rates and cuts in health care funding.

Some of her suggestions to increase accountability are controversial. She advocates public disclosure of postoperative complication and death rates with respect to individual surgeons and hospitals, routine competency testing for physicians, and a minimum volume requirement before physicians can perform a given procedure. Her book is well written and has many strengths. Priest makes her case for greater public disclosure of information with a good mix of anecdote, evidence and illustrative quotes from experts. Each chapter features a list of questions to be directed at individual surgeons, hospitals or government. She also proposes "things you can do to help," although often these are variants of "lobby the government."

How will Canadian physicians react to this book? I suspect that many will speak out against it without reading it. Surgeons may be annoyed to find them-

selves a clear target of her arguments, while anesthetists and others will be happy to hide below the parapet. Many will be affronted that their competence is being called into question and that the book calls for more public accountability. There will be bluster about the erosion of trust in the physician-patient relationship. Others will dismiss much of the evidence Priest offers by claiming that her data are flawed. Some will see the move to greater openness as a way to improve the quality of care; others will be much more cautious, judging that the public will become unnecessarily worried and that their faith in the medical profession will erode. For the issue at the heart of this book is whether it is better to allow public access to imperfect data with caveats, or to rely on professional self-regulation.

There are many problems associated with publishing performance indicators. Although Priest cites evidence that the publication of hospital death rates in the US has led to a decline in those rates and that poor surgeons have been encouraged to move on, she fails to discuss whether the reported improvement in hospital performance is real, or whether in fact it resulted from other strategies. It would be relatively simple for a hospital to "doctor" its performance indicators, by relaxing the coding criteria for diagnosis (for instance, assigning the same code to cases ranging from severe angina to mild heart attack would have the effect of increasing the number of patients

with heart attacks seen in hospital) or by discharging patients earlier so that they die at home rather than in hospital. These methodologic issues are more likely to be resolved, as has been argued in the research literature, by publishing data than by censoring it.

A more fundamental issue, which is not really addressed in her book, has to do with the practical implications of what Priest proposes. For example, what would happen to the provision of care if every informed patient sought the "best" surgeon or the "best" hospital (hardly an option for many Canadians)? My main criticism of Priest's account is that it does not acknowledge that most care received in Canadian hospitals is of high quality and provided by conscientious and skilled doctors. This point could have been made without any damage to the case for greater accountability.

The reality is that only a few bad apples spoil the barrel. Consider the case of the Bristol heart surgeons. In a case strikingly similar to that of the Winnipeg Health Sciences Centre pediatric cardiac surgery program, two surgeons in the UK were found guilty last year of serious professional mis-

conduct in connection with the deaths of twenty babies who underwent heart surgery. This case is different, however, in its far-reaching consequences. Richard Smith, editor of the *British Medical Journal*, invoked W.B. Yeats in lamenting that medicine in Britain is "All changed, changed utterly." Indeed, the very issue of self-regulation by the General Medical Council is being called into question. A public enquiry is currently hearing submissions; its recommendations will likely contain suggestions similar to those put forward by Priest. In anticipation of the council's



Fred Sebastian



findings, the senate of the Royal College of Surgeons of Great Britain and Ireland has already recommended that surgeons undergo professional review every five years.

Most physicians will recognize some legitimacy in what Priest preaches. They may disagree on the extent of the problem and on whether the solution lies in self-regulation or in public disclosure. Where you stand on this issue rather depends on where you sit. Nevertheless, we only have to look at the far-reaching impact of similar cases in the UK to realize that this issue will not go away. Public disclosure is coming to Canada. Hospital performance report cards will soon be published in Ontario. This is a book that deserves to be widely read.

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### One thousand words



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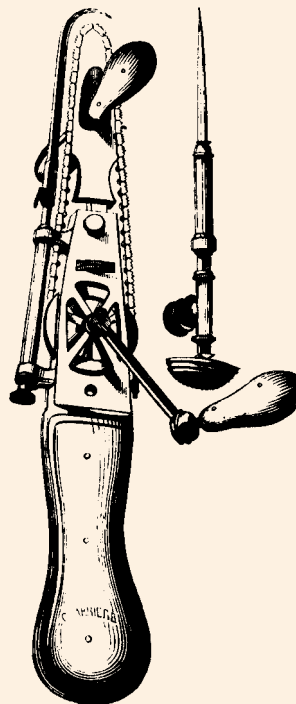
Operation in progress at a travelling medical clinic in rural Alberta in the 1920s.

### Image of the profession

## The osteotome

The impetus for a new field often comes from new technology. Radiology evolved within a few years after Röntgen's discovery of x-rays in 1895 and the Curies' discovery of radium in 1898. Orthopedics became a specialty with the help of a new instrument, the osteotome, invented around 1830 by the German Bernard Heine.<sup>1</sup> This illustration from a contemporary inventory of surgical tools<sup>2</sup> shows clearly that this clever master of prosthetics had in fact invented the chain saw. The links of the chain carried small cutting teeth with the edges set at an angle; the chain was moved around a guiding blade by turning the handle of the sprocket wheel.

The osteotome made it easy to cut through hard bone without the impact of hammer and chisel or the jolts of a reciprocating saw. The surgeon skilled in its use could now resect bone without splintering it, perform craniotomies with smooth-edged



**Heine's osteotome as illustrated in Gaujot and Spillman.<sup>2</sup>**

holes, and cut in topographies that did not permit access to a circular saw — without damage to surround-

ing tissue, all by himself, and with a minimum of force and time. Heine became an instant celebrity and was invited to demonstrate his invention at clinics all over Europe and even at the Court of the Czar. In 1834 he won the coveted Prix Montyon of the Académie des Sciences in Paris. For his studies on bone regeneration, the University of Würzburg appointed him professor of orthopedics in 1838, the first such chair anywhere, although he had never studied medicine. Heine died nine years later of tuberculosis at age 46.

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