Book review


Better: a Surgeon’s Notes on Performance
by Atul Gawande
273 pages including notes 259-69, no index.
US$24

[1] THIS reviewer has previously commented favourably on the author’s earlier book Complications (2002). His current book considers how medical outcomes can be improved by raising the performance level of practitioners, that is, leaving aside advances in medical science, there still exists room for improvement just by better utilising the current state of medical science (and performing better).

[2] Gawande’s research interest is in improving surgical care in the US and developing countries and forms the basis of this collection of essays, many of which have previously been published in the New Yorker and The New England Medical Journal and other publications. I can recall having previously read several of these articles in the New Yorker. While this volume lacks an index it does have chapter notes, allowing the reader to delve deeper if desirous of doing so.

[3] The common thread of these essays is to show how modern medicine and its practitioners can deliver improved results by pushing themselves to do better with their currently available skills and technology. There are thirteen articles (if we include the Introduction and the Afterword) under three sections headed “Diligence”, “Doing Right” and “Ingenuity”. In truth, these divisions are porous and many of the articles could have been included under any or all of these headings. There is one article, “Piecework” that somehow appears out of place — after completing his training the author was surprised to be offered his first job when the chairman of surgery told him he was to nominate what he, the job offeree, thought was an appropriate salary. If Gawande’s nominated salary was reasonable, then that’s what he’d be paid. If not, presumably he’d be advised to look elsewhere. As a novice, Gawande was stumped. Just how much is a newly-minted “junior” surgeon worth? It was difficult for this reviewer to appreciate how this chapter could be included within
the rubric of improved performance. Certainly it provides an interesting insight into the remuneration of medicos in the US and the arcane rules to which they are subjected by Medicare (the US government’s insurance program for the elderly) and the private health insurers. I am pleased that the author provided this inside look at the US health system but I do not understand its relevance to the book’s thesis.

Diligence

[4] Hygiene and cleanliness are covered in the essay on the washing of hands – and the difficulty that practitioners (including the author) have in compliance. However, much of the adverse outcomes and extended stays in hospital wards are a direct result of failure to adhere to basic hygiene. The answer lies with nagging nurses and attempts to make neglect almost impossible: the easiest way is to negotiate the hygiene route.

[5] Another chapter describes the improved treatment of battlefield casualties because of speed – the necessary evacuation from the battlefield to a well equipped surgical hospital within minutes, and, where necessary, evacuation to the US military medical facility in West Germany or even the Walter Reed Hospital in the US. In 2003 when the current Iraq war commenced, a medical evacuee from Iraq took 8 days to get to Walter Reed. Today it is less than 4. In the time of the Vietnam war it was forty-five days. The reduction in time has boosted the survival rate of the wounded despite advances in the destructive power of modern weaponry.

[6] The next division, Doing Right is concerned with the ethical problems encountered and how they affect the practice of medicine – intimate medical examination carries with it the possibility of allegations of sexual harassment which can inhibit the better practice of medicine – if the doctor is more concerned with possible charges of sexual impropriety than a proper diagnosis then his (or her) performance as a medical practitioner is compromised. Other chapters cover medical malpractice litigation and the participation by doctors in state sanctioned executions of convicted criminals. Legal readers may be interested to learn that the subject of the malpractice litigation chapter is a onetime surgeon who had himself been the defendant in three such cases. Because of his curiosity he embarked upon a legal education and fell into tort litigation on behalf of medical plaintiffs by default when
the medical defence insurers couldn’t accept his limited experience. Today he is a successful plaintiffs’ litigator and carefully assesses his cases before accepting them. The author is persuasive in exposing the canard that litigation is the only means of ensuring the medical profession improve their ways. Further, the author does not deny the need for proper compensation where the medical practitioner has fallen short.

[7] In the following chapter Gawande considers the moral question facing the practitioner participating in the putting to death of those persons convicted of horrendous crimes. The author frankly admits that he does not oppose the death penalty – however, he is unable to reconcile the medical ethos with participating or otherwise assisting in the putting to death of a condemned criminal no matter how heinous the crime.

[8] Where a court rules that the US Constitutional prohibition against “cruel and unusual punishment” requires the attendance of a physician to ensure that everything proceeds according to plan then the author dissents. His position is that if executions cannot proceed without an attending physician, the ethics of the profession prohibit the attendance and assistance of the practitioner with the consequence that the author would have it that executions not be carried out. His objection is not to capital punishment itself but to the participation of practitioners in the process. This chapter makes for uncomfortable reading but it is well written and the reader can only admire the clarity with which the author canvasses the different aspects of the issue.

[9] The next chapter (“Fighting”) resonated with this reviewer because of two recent instances that should be familiar to Victorian readers. The allegations against the suspended head of the Alfred Hospital’s Trauma Unit include the suggestion of unwarranted and needless surgery on patients who were unable to benefit – the suggestion being that the surgeon was more interested in performing fee-earning operations even where the operation was of no benefit to the patient and may even have added to the patient’s distress and discomfort in their last days. Another instance was the Coroner’s finding in a case of a first-time birth where, following a tragedy of errors, the mother died. The evidence before the Coroner included that the physician accompanying the mother in the ambulance to the Monash Medical Centre did not attempt any life-preserving actions because of his belief that such actions would be
futile. Upon arrival at the Medical Centre, the emergency physicians did so attempt to revive the patient – who is to say who is wrong? Certainly, if I were the patient I would want (and expect) my practitioner to perform to the utmost. I do not believe that I differ from most medical patients. This willingness to attempt daunting tasks has a later echo when the author recounts the acquired abilities of third world surgeons where necessity demands the boldness to try.

[10] The final section Ingenuity deals with the improved performance levels of those demanding practitioners who refuse to accept the norm. The introduction into medical practice of a “scoresheet” to assess the level of care to be provided to newborns has seen the rate of survival of premature and sickly babies raised. There are moves afoot in Australia to provide a scorecard for patients to assess both their practitioners and their hospitals. Such scorecards can induce those performing in the middle of the range to attempt to emulate the higher flyers: why is it that some hospitals and practitioners continually achieve better outcomes? The answer lies in diligence and perseverance and an insistence upon the highest performance.

[11] Why shouldn’t we rest our hopes on further advances in medical science? Such advances have done much for modern civilization. Consider for example Dr Gawande’s colleagues: Dr Mark Simon, 29 years old and suffering from cystic fibrosis. Sure, human ingenuity will one day find the cure and solve CF. But not soon enough for Dr Simon who is only too aware that the average life expectancy for such patients as him is just thirty-three. He wants and needs the performance standards of the Minneapolis experts who consistently perform “better” in their management of CF patients with the “better” being capable of objective assessment. The Minneapolis CF patients consistently have longer lifespans and better lung functions than those of patients attending other hospitals.

[12] Consider the practitioners that the author met on his recent trip to India. Necessity requires these practitioners to be all-rounders. The luxury of referring on to other specialists just doesn’t exist even if the budget to do so did. There are no other specialists. There is no budget for referring on. He was asked his preferred technique for removing bladder stones. Gawande replied that his technique was to call in a urologist. The surgeons on the sub-continent do not have the luxury enjoyed by
comfortable New England surgeons and consequently they must develop abilities that outstrip those of Western surgeons, for example, neurosurgery performed in a department that has no neurosurgeon.

[13] This cynical reviewer with a jaundiced view of all professions including the medicos was reminded that the practice of medicine can be a noble profession.

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