Health tsars: more like Peter the Great than Ivan the Terrible

TOPHAM PICTUREPOINT

In 1999 the Department of Health appointed the first of nine health tsars to help shape a variety of services from primary care to cancer, heart disease, and services for children and older people. This was the first time clinicians could direct change at a national level from a department of the government. Five years down the line Burke (p 126) asked them to summarise their achievements and other people to assess their work. In an accompanying editorial Burns (p 117), the former cancer tsar for Scotland, tells us what it takes to be a tsar: be open to ideas and have money to spend, but also be ready to take jealousy and hostility from some of your colleagues.

POEM*

Earlier mobilisation improves pneumonia outcomes

Question Does early mobilisation improve outcomes in patients with community-acquired pneumonia?

Synopsis Everyone looks healthier sitting up, don't they? Previous studies of myocardial infarction and orthopaedic procedures have shown improved outcomes with early mobilisation. These researchers applied that thinking to hospitalised patients with community acquired pneumonia. Patients (n = 458) admitted to 17 general medical units were randomised by medical unit to early mobilisation (encouraged to get into an upright position for at least 20 minutes during the first 24 hours of hospitalisation, with progressively increased mobilisation thereafter) or usual care. A large variety of variables and outcomes were measured, but the primary outcome was length of stay. Groups were similar at baseline; approximately 25% were younger than 50 years and 25% were older than 80 years. Most received their antibiotics within eight hours. The mean length of stay was lower for the early mobilisation group (5.8 *v* 6.9 days; 95% confidence interval 0 to 2.2). The results were stratified by the pneumonia severity index (PSI) score, where I is the lowest severity (what were they doing in the hospital in the first place?) and V is the highest severity. The greatest difference in length of stay occurred among the 86 patients with an intermediate PSI score of III (4.9 *v* 7.4 days; 0.2 to 5.0), and the authors speculate that patients who were less sick were going to get better quickly whether they were lying down, sitting up, or standing on their head, while those who were most sick were less likely to benefit from this simple intervention. There was no difference between groups in the risk of death or readmission.

Bottom line Early mobilisation, beginning by having patients sit up for at least 20 minutes in the first 24 hours after admission, reduces the length of stay for patients with community acquired pneumonia.

Level of evidence 1b (see www.infopoems.com/resources/levels.html). Individual randomised controlled trials (with narrow confidence intervals).

Mundy LM, Leet TL, Darst K, et al. Early mobilization of patients hospitalized with community-acquired pneumonia. *Chest* 2003;124:883-9.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

Doctors mangled by "justice"

This morning I spent three hours in the chambers of a Queen's Counsel. It was like a stage set. The open fire crackled. The view over the 18th century lawns was magnificent. The room was lined with leather bound reports from the appeal courts of the 1890s. It was impossible not to be impressed by the forensic precision of the lawyers' minds, and we all had a lovely time. But many doctors' experiences of the law are nothing like this Georgian arcadia but rather a brutal mangling. I've read of two such cases this week.

The first was in *JAMA* and described the case of a family physician in an American academic centre who saw a 53 year old man for the "routine physical" that is common in the United States but uncommon in Britain (2004;291:15-6). The physician and patient discussed the possibility of measuring the man's prostate specific antigen. The easy thing would have been to simply order the test. Instead, the physician opted for the modern model of patient partnership. He explained the pluses and minuses of the test, and the fully informed patient decided against. Three years later the physician was sued because the patient had developed metastatic prostate cancer and died. The physician was exonerated, but his academic programme is liable for a million dollars.

This story is likely to strike terror into many doctors. "This could easily have happened to me," might be the first thought. "It's so unjust" might be a second: "The doctor goes to all this trouble, practising medicine in the way we teach now—and still gets screwed." Then there are the implications for practice across the United States. Many patients—often prompted by the media—are asking to have their prostate specific antigen measured. Will doctors discuss with them the risks and benefits of the procedure—or will they simply suggest that the patient has the test?

The "villain" in my second story is less the law and more the media. The *Daily Mail* last week carried the headline "The killer doctor back working in hospital" with a picture of the doctor (7 January, p 5). The doctor had been found guilty of manslaughter for failing to diagnose a knee infection that complicated surgery and led to the death of a young man. "He escaped a jail term after his barrister pleaded that his career was in ruins," reports the newspaper; and he was not struck off by the General Medical Council.

The doctor has now been re-employed in a training position, greatly upsetting the father of the young man who died. "I don't think," says the father, "there is any normal human being in this country who would say this is right." To suggest that anybody who thought it was right—including the courts, the GMC, and the employing authorities—are not "normal human being[s]" may be strong, but it's understandable and excusable in a bereaved father. What is inexcusable is to report the story in a national newspaper.

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