patient is worried by the "rustling" of the appliance. Secure fitting of the appliance to the skin is most often achieved with the adhesives Karaya or Stomadhesive, and if there are any irregularities of the skin contour these can be filled with Karaya gum. Odour may be controlled by using deodorant drops in the bag or by using a charcoal filter, which is either fitted to the bag or, more frequently, comes as an integral part of the appliance.

The patient will soon establish his own routine for emptying the bags. He will often keep a variety of necessary items with him, including a plastic bag for soiled bags, tissue or gauze to clean the peristomal skin, a pair of scissors, a clean appliance, and so on. The disposal of bags may be a problem. Although many authorities will collect used bags, patients often wrap them in newspaper and put them in the dustbin or burn them. They should not be flushed down the toilet as they are likely to block the drain. Most patients cut the corner of the bag, empty the contents, rinse the bag out, wrap it in a newspaper, and place it in a plastic bag.

Several companies have many years' experience with a wide range of appliances. Close cooperation with such companies is encouraged, and one often finds that the advice of their representatives is based on extensive experience. Many of them produce helpful booklets, which can be given to the patient.

Support groups

Besides a medical team and general surgical nursing staff, many centres now have special stoma care nurses (enterostomal nurses). Stoma care became an option for nurses in the 1950s; now there are more than 200 enterostomal nurses. These specialist nurses often establish stoma care clinics and may also visit patients at home. They are often available for advice at the hospital.

Useful addresses

Colostomy Welfare Group, 38-39 Eccleston Square, London SW1 1PB 01 828 5175

Ileostomy Association of Great Britain and Ireland, Amblehurst House, Chobham, Woking, Surrey GU24 8PZ 09905 8277

Urostomy Association, 8 Coniston Close, Dane Bank, Denton, Manchester M34 2EW 061 336 8818

There are national bodies uniquely concerned with the support of patients with ileostomies, colostomies, and urostomies. One of the ways in which these organisations help is by arranging for patients to be visited before surgery. After the operation they provide much needed psychological support to those who want it.

I thank Sister D Jones for her advice in the preparation of this article.

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Letter from . . . Chicago

Distrust

GEORGE DUNEA

These are times of distrust between the government and the doctors. The government wants to save money and justify what it spends. Having long paid the piper it now wants to play the tune—to control, to regulate. All this was foreseen 20 years ago when the government first began to pay for health care, and now the predictions have come true. "Physicians no longer control the medical care system to the degree they did in the relatively recent past," says a former medical dean, "and they are likely to have even less control in the future."[1] "This loss of autonomy is extremely frustrating for doctors," admits Medicare's chief administrator, a doctor himself. He recognises that "doctors are pulling their hair out when bureaucrats like me tell them how to practice medicine." But he predicts that in the future there will be even more regulation because "the government must be a prudent buyer of health care."[1] The doctors, however, feel harassed and irritated.

The bureaucrats' earliest incursions into medicine were actuated by rising costs. Later came an interest in quality assurance, fuelled by unrealistic expectations, activists' complaints, and demagogue politicians. Rumblings about unnecessary surgery, especially hysterectomies and caesareans, persisted; and questions about geographical differences in surgical rates could not be quite explained away by varying incidences of disease, social and cultural differences, underservice, different referral patterns, or lack of consensus on how medicine should be practised.[2] One study recently concluded that even by liberal criteria 17% of coronary angiograms, 17% of gastroscopies, and 32% of carotid endarterectomies done in certain areas were unjustifiable.[3]

So gradually the bureaucrats warmed up to the role of patient

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advocates and arbitrators of what is good medical care. In 1986, in response to requests by consumer groups under the Freedom of Information Act, they began to publish mortality rates of Medicare patients (over 65 years) in America's 6000 hospitals. Though intending "to inform, not infuriate," they achieved the latter. Stung to the quick, the hospitals protested that the data were misleading and likely to cause unnecessary apprehension among patients. But the government stuck to its guns in what it called its "advocacy in informing the public"—and did it again this year. Only this time it gave the hospitals 30 days to write back, and then published alongside the data the explanations supplied by those hospitals that had received the report in time to respond. Again the medical and hospital societies protested, calling the data primitive and inadequate, a waste of effort and resources that fails to consider patient mix, severity of illness, socioeconomic data, and local characteristics. But at least the data showed that hospitals doing fewer operations had more deaths. It allowed others to advertise that "we have the lowest mortality for heart surgery in the country."[4] It also made Medicare's boss feel good: "I am very proud of what we are doing," he told the newspapers, calling the report a valuable tool.

But valuable or not, it was certainly bulky—like seven fat telephone books. Encompassing 10 million admissions and 735 000 deaths occurring within 30 days of admission, it used that time frame to discourage hospitals from sending out patients with terminal illness to improve statistics. Though available to the public for $69, it is hardly expected to become a best seller, despite the useful tip that patients should seek their doctors' help to interpret the data. The report concedes that a hospital placed outside the predicted range is not necessarily better or worse than another, though suggesting that the 5% that were quite far out might be worth a closer look.[5] Some people also warned that hospitals might want to use the data to evaluate or even penalise their doctors.[5]

Monitoring by PROs

Yet already the government itself has done more than its fair share of disciplining. To monitor the doctors, it set up a network of regional peer review organisations (PROs), the latest in a series of bureaucracies that have spanned the medical scene over the past 20 years. This particular creature, however, is meaner though by no means leaner. In fact, private organisations now compete for lucrative contracts to oversee a certain region, reduce hospital admissions and length of stays, save money, and monitor care. A PRO contract could mean millions of dollars, with jobs for clerks, managers, nurse reviewers, and doctors, with pressures to produce results, to show that money is being saved, that the public is being protected from incompetent doctors.

As a result doctors have been dragged before star chamber committees and stripped of their rights to treat Medicare patients. Some doctors have spent thousands of dollars on legal fees to defend themselves. Conscious of being watched, many doctors are beginning to practise an undesirable brand of defensive medicine, ordering tests with an eye on the reviewers, admitting or discharging patients merely because the criteria say so, calling in consultants to cover all bases, and giving intravenous fluids to satisfy the intensity of services required by PRO.

The review itself is done by nurses, who descend on the hospital in swarms, intimidating the medical records librarians by their insistence on being attended to immediately. Then they pore over the records of patients often discharged from the hospital and forgotten long ago, using a book of written criteria for each disease. There are criteria for medical illnesses and criteria for surgery, criteria for who should be admitted, for what tests are mandatory, what treatment must be given, what follow up is required. The criteria are rigid and naive, seemingly written not by practising doctors but by residents, bureaucrats, or academicians. They reflect what is written in the books not what happens in real life. If the nurse finds deviations from the criteria she refers the case to the medical reviewers for further evaluation. In many cases the doctor will then receive a letter questioning his practice. Why did you start antibiotics without first looking at a gram stain? This in a patient ill with pneumonia and high fever, who could not bring up sputum anyway. Did you think of measuring the packed cell volume after transfusion—and why was no pelvic exam done—and why were there no progress notes for three days in succession? This to a doctor who spent many months looking after a patient with terminal cancer with metastases. Then so many doctors were criticised for not treating asymptomatic bacteriuria in the elderly that they eventually banded together and produced enough documentation from the literature to force the local PRO to reverse its decision in a four page learned dissertation.

Even more distressing was the reviewers' perspective of a 95 year old obtunded patient with bilateral strokes and fed through a nasogastric tube, who was transferred out of an acute hospital after a six months' stay. He was sent to an extended care facility where he died two days later. The doctor was severely criticised for transferring what the reviewers deemed to be an unstable patient. Also incurring the displeasure of the reviewers was the case of another geriatric patient with end stage cardiomyopathy, who was sent home after several months in hospital. A week later, taking a turn for the worse, he was readmitted to the hospital and died the next day. The reviewers denied the entire admission (meaning that the hospital would not be paid) and threatened to disbar the doctor on grounds that the patient had been sent home prematurely. In rural areas, especially in Texas, doctors have been banned from treating Medicare patients on highly questionable grounds. In some instances entire townships were deprived of the services of their only doctor.

Cookbook philosophy taking over

Yet how can anybody evaluate the quality of care by reviewing one year old records and without ever having seen the patient? How can medicine be practised by the book when each new day calls for intuitive decision, short cuts, compromises, strategies designed for this patient only and nobody else? Has the art of medicine declined to where cookbook prescribing prevails over experience and clinical judgment? But already the cookbook philosophy is taking over. For who would dare to postpone a certain prescribed intervention when the blood level rises over the magic number listed in the book? Who would ever not order cardiac monitoring for a patient with chest pain? But when the electrocardiogram and cardiac enzyme activities were normal in such a case and the doctor ordered a barium swallow, the reviewers objected because the criteria apparently forbid gastrointestinal *x* ray examinations after "cardiac pain."

Yet there are signs that reviewing is becoming institutionalised. For retired doctors it is a way to fill in time and earn a little money. Other reviewers are young, barely out of training, inexperienced in clinical medicine, easily coopted by the bureaucrats; others are established in practice but need the extra income in these days of competition for patients. Already the reviewers are consolidating their position, as shown by the creation of an American College of Utilization Physicians. It is easy to see how such a vociferous body of praetorian guards would fight to maintain its position, especially since "quality assurance" sounds at least as respectable as motherhood. But none of this after the fact review of ordered tests has anything to do with excellence in medicine, with thoroughness in history taking, with accurate assessment of physical signs, with a reasoned approach to the whole patient by an experienced doctor. It is merely a window dressing to allow the bureaucrats and politicians to tell consumer groups and patients' advocates that the public is getting its money's worth.

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