



Terry Pratchett at the Dignitas clinic, face to face with the lethal drug for assisted dying, p 1366

VIEWS & REVIEWS

For-profit companies will strip NHS assets under reforms

PERSONAL VIEW **Lucy Reynolds**

The unfolding cautionary tale of Southern Cross illustrates the fundamental problems with the outsourcing of public services to corporate bodies (*BMJ* 2011;342:d3535). Its crisis originated when it was bought by private equity firms, which buy companies, like Southern Cross, that own unmortgaged land and buildings. After selling, leasing back, or borrowing against these assets, they dispose of the company, now saddled with debt. Their aim is to extract rather than to add value. Any publicly listed company may be a target because its shares can be acquired on the stock market.

Southern Cross is now threatened by insolvency. Despite pre-existing concerns about inadequate staffing levels, it claims it can cut 3000 frontline posts without harming quality of care. If this is true, the company has previously been charging councils, and residents who fund their own care, for unnecessary staff. The directors have announced cuts in nursing, catering, and cleaning jobs, but not in management pay rates, where savings would not further prejudice care standards.

The reason that any commercial enterprise exists is to make profits, and the over-riding duty of the directors, enshrined in company law, is to maximise the money the company generates for its shareholders. Whether the company sells bread or breast cancer screening, its activities are a means only to a financial end. In contrast, NHS managers have no such constraints, and their duty aligns with the best interests of their patients and the wider community.

Private companies are constantly pressured by the stock market and shareholders to think in the short term and to maximise dividends, which in the case of outsourcing contracts come at the expense of spending on service provision. Their duty to their shareholders requires them to cherry pick the most profitable services at the expense of the rest, and to spend as little as they can get away with on service provision to maximise dividends. They have no interest in the social or ethical dimensions of

healthcare. Large private providers often undercut public providers to achieve market entry, but the true financial and human costs emerge later when the public sector has to pick up the pieces.



TIM IRELAND/PPA

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To protect the quality of corporate sector provision the government must oppose these embedded perverse incentives by externally regulating every aspect of quality. Yet, in practice, it is unwilling to fund such regulators adequately in the face of corporate lobbying against “red tape,” so profits rise at the expense of quality.

We can expect these problems of outsourcing to corporate bodies to be multiplied many times over if the Health and Social Care Bill becomes law. Although the white paper talks of empowering general practitioners and local communities and facilitating patient choice, the content of the bill itself bears little relationship to these goals. Most commentary has been on the white paper and not the bill itself; an honourable exception is the analysis by Pollock and Price (*BMJ* 2011;342:d1695). Because there has been little reporting on the substance of the bill, few are aware of the true content and direction of the changes proposed. As the white paper suggests, the bill facilitates involvement of GPs in commissioning consortiums. However, it offers the same opportunity to any company that “wishes to be a provider of primary medical services” (clause s14).

Fifteen clauses (ss125-131, 168-175) collectively create a new insolvency regime for hospital foundation trusts. You might wonder why this is a priority in NHS reform. Clues emerge in clause s293, which removes the prohibition on sale of NHS assets, and s160, which allows foundation trusts to raise loans for the first time. The government remains mute about the purpose of these innovations, but their passage would enable private equity companies to buy NHS facilities and asset strip them. The bill bans the government from stopping them: clause 4, which adds a s1C to the National Health Service Act 2006 guarantees “that any other person exercising functions in relation to

the health service or providing services for its purposes is free to exercise those functions or provide those services in the manner that it considers most appropriate.”

Disturbingly, clause s12 specifically enables privatisation of high security psychiatric services. What may we expect once these services are run by providers which prioritise shareholders’ pockets above public welfare? It was the privatisation of hospital cleaning that brought us deaths from meticillin resistant *Staphylococcus aureus*.

The government has failed to explain why the NHS, ranked overall second in health outcomes and first in cost effectiveness among seven developed countries (United Kingdom, New Zealand, Canada, Germany, Netherlands, Australia, and the United States, Commonwealth Fund, 2010, <http://bit.ly/aRKQV7>), needs to involve profit making providers. Passage of this bill would move us towards a US-style corporate dominated system. The US produced the worst scores on these measures in this 2010 comparison and was ranked consistently lowest overall in previous Commonwealth Fund studies, in 2004, 2006, and 2007. The US achieves worse health outcomes than not only these developed countries but even impoverished Cuba (WHO, 2009, <http://apps.who.int/ghodata/>), and at an annual per capita cost (\$7410, 2009, <http://apps.who.int/ghodata/?vid=80201>) more than double the UK’s (\$3285) and 10 times Cuba’s (\$707).

If David Cameron honestly intends to avoid NHS privatisation, the Health and Social Care Bill must be amended to exclude for-profit corporate bodies from commissioning and service provision. If not, he signals clearly his choice to benefit potential shareholders at the expense of patients and taxpayers. Concerned readers should contact their MPs urgently to press for this change.

I thank Professor Martin McKee for his guidance in researching and presenting this topic.

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- For all the latest visit www.bmj.com/nhsreforms
- News: UK prime minister “guarantees” welfare of residents of struggling nursing home chain (*BMJ* 2011;342:d3535)

TELEVISION REVIEW

We are not alone

What pressures does assisted dying place on loved ones? A programme in which Terry Pratchett sees a man take his own life stirs feelings in **Desmond O'Neill**

Terry Pratchett: Choosing to Die

First shown on BBC2 on 13 June 2011

www.bbc.co.uk/programmes/b0120dxdp

Rating: ******* 

One of the most insightful passages in Joseph Conrad's *Heart of Darkness* occurs at the beginning of the novel as they cruise down the Thames, when the narrator outlines what really captivates in a narrative. To him "the meaning of an episode was not inside like a kernel but outside, enveloping the tale which brought it out only as a glow brings out a haze, in the likeness of one of these misty halos that sometimes are made visible by the spectral illumination of moonshine."

I was reminded of this while watching the Terry Pratchett programme on assisted dying. In this documentary, the *Discworld* author, who was diagnosed as having Alzheimer's disease in 2008, travels to the Dignitas clinic in Switzerland to see assisted suicide first hand. My attention should have been grabbed by the central protagonists, Peter with motor neurone disease, Andrew with multiple sclerosis, and Terry with Alzheimer's disease, but in fact I was emotionally transfixed by the conflicted emotional reactions and body language of those close to them. From the deep discomfort of Andrew's mother, to Terry describing Peter dying "almost in the arms of his wife," to the clear unease of Rob, Terry's longstanding

personal assistant, we got a strong sense of the demands that assisted suicide places on those dear to people who choose, or are thinking of choosing, this form of death.

It is these witnesses who add an extra dimension to the debate about coercion and assisted suicide. Usually this concern focuses on the person who is the subject of the death, but a broader view helps us to see how others might also find themselves emotionally pressured. If a strong willed person decides to take this route it could place a parent, adult, child, or partner in a difficult position, neither truly wishing for the death nor feeling it possible to let it happen unaccompanied.

It is a huge burden to bear, and parental, spousal, or filial loyalty may make it a challenge not to find your emotional and moral compass twisted. Not only is there the difficulty of coping with the rejection of the love, trust, and willingness to continue to support through progressive disability, but there is also a pressure to join in with the justification of the process.

A further level of emotional coercion comes into play with us as care professionals and "someone has to do it" arguments. The tenor of the deeply distressing final scene, with its contrasts of banality and terror, reminded me of Atul Gawande's profound and empathic

"Not wishing to be a burden" is in turn a different type of burden on those who care for and love us

reflections on how decent and caring physicians get involved in the death penalty (*N Engl J Med* 2006;354:1221-9). This article should be a catalyst for the development of an ethical and emotional articulacy to protect us (and those we care for) from such pressures, an articulacy that is not always easy to display in our bluff, practical, and often utilitarian style of medical discourse.

And indeed, we might be supported in this by a positive, if unintended, insight into the meaning of life with disability, which was again "outside of the kernel" of the intended narrative of this largely polemical documentary. It was impossible not to be struck by how the supportive relationship between Rob and Terry shone through as an example of adaptation to progressive neurological illness.

From the way that Rob supports him in his new way of writing, through dictation and feeding back the results (his new book, in a touch of possibly Pratchett-like irony, is called *Snuff*) to their evident pleasure in companionship and exploring new things, such as drinking wine together on the train as the snowy landscapes passed by, I was struck how we easily we can forget that the warmth of relationships helps to keep our cognitive skills in perspective.

"Not wishing to be a burden" is in turn a different type of burden on those who care for and love us and a rejection of the deeper truth that our autonomy is, in the final analysis, exercised in the embrace of others. It undermines the urges, however imperfectly executed, that we all develop as a result of the care and nurture of those that we love: it also erodes the universality of dignity as a quality that is not affected by disability or care needs.

No one indeed is an island, and John Donne's poetic inspiration that "any man's death diminishes me because I am involved in mankind" never rang more true than as a counterpoint to this sad documentary. I felt diminished both as a doctor and a human by the deaths in this documentary, and was moved to hope that we will enjoy the richness of Terry Pratchett, in whatever guise, for many more years to come.

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- Head to Head: Should the law on assisted dying be changed? (*BMJ* 2011;342:d2355)
- Obituary: Ann McPherson (*BMJ* 2011;342:d3424)
- Observations: Half truths about assisted dying (*BMJ* 2010;341:c7282)



Peter Smedley, aged 71, with his wife (left). He has motor neurone disease and is about to take the lethal barbiturate at the Dignitas clinic while being filmed for Pratchett's documentary

BETWEEN THE LINES Theodore Dalrymple

Troubled hearts



Ford Madox Ford: a tale of the heart

It sometimes seems as if the respect given to doctors, or at least to doctors' orders, is inversely proportional to the state of medical knowledge. The more we know (as a profession, I mean, not as individuals), the less uncritically we are believed.

The best known book of Ford Hermann Hueffer (1873–1939), who changed his name to the less Germanic sounding Ford Madox Ford, was *The Good Soldier*. It is an exceedingly complex love story, first published in 1915, and is more eternal octagon than triangle. It would be an excellent intellectual exercise to summarise it in, say, 30 words, but I won't even try.

However, heart disease, or alleged heart disease, plays a large part, as well as the self confident but ignorant pronouncements of doctors. Two of the four most important characters are supposed to have such disease. Edward Ashburnham, a philandering British officer, supposedly has heart trouble: "a heart," in the parlance of the day, brought on by "approximately, polo, or too much hard sportsmanship in his youth."

Florence Dowell, the narrator's wife, is a rich American whose heart trouble

allegedly started on the honeymoon trip to Europe, caused by "a storm at sea." This rendered her, supposedly, a complete invalid, so much so that her husband was ordered by doctors to avoid all conversational subject matter that might speed up her heart.

If she became excited over anything or

if her emotions were really stirred her little heart might cease to beat. Once arrived in mainland Europe, the doctors forbade her from crossing over to England. The narrator says, "I daresay they were honest enough, as things go. They probably imagined that the mere associations of the steamer might have effects on Florence's nerves. That would be enough, that and a conscientious desire to keep our money on the Continent."

But this cynicism about the doctors' motives is after the fact; in the story, the narrator, John Dowell, obeys the doctors to the letter. Captain Ashburnham and Florence use their invalidity as a screen for conducting an affair. When Florence discovers Ashburnham paying his attention to Nancy, his wife's ward, she rushes to her room, where she is found dead clutching a bottle of amyl nitrite, John Dowell first supposes, but really of prussic acid, as he later learns.

Florence also has an uncle, Uncle Hurlbird, who suffers not so much from heart disease as from having been told by the doctors that he has it (which he hasn't). When he dies at 84 years old, having long treated himself as an invalid, he leaves his fortune to Florence, whose suicide comes only five days later, so that the money passes to her husband. His only request was that some of this money be used to found an institute for fellow heart patients. This causes a dispute among his other relatives as to whether the money should be used for this purpose, as he wished, or for an institute for lung patients—Hurlbird really had an infection of the

lungs, as proved by postmortem examination.

Those were the days of opinion based medicine. Opponents of evidence based medicine

would do well to read *The Good Soldier*. On the other hand, I don't think medicine will ever entirely free itself of opinion; but that, of course, is only my opinion.

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MEDICAL CLASSICS

And the Band Played On

A book by Randy Shilts, published 1987, and a film directed by Roger Spottiswoode, released 1993

In these days of swine flu, rapid response programmes to outbreaks of communicable disease, and digital communications technology, it is easy to forget there was a time when communication about epidemics did without mobile phones, email, or social media. Antiretroviral treatment may now be widely available in the West, but when HIV and AIDS first appeared in the United States and Europe, the ensuing pandemic left experts baffled, and exacted a heavy toll. The US alone had more than 65 000 cases by 1988. Were this to happen today the panic would be unimaginable.

The late Randy Shilts's 1987 classic, *And the Band Played On*, encyclopaedically chronicles the events from the death of the Danish doctor Grethe Rask in the late 1970s (only later was it found she died from AIDS related pneumocystis pneumonia). Randy Shilts was a former journalist with the *San Francisco Chronicle*, and based the book mostly on his own reporting from San Francisco in the 1980s. He blamed the rapid spread of the disease on homophobia, political and institutional failures during the Reagan administration, scientific competition at national and international levels, business interests, and the seemingly collective will of society to bury its head in the sand.



"I get their money when they come in; you get their money when they come out," one particularly hard nosed bathhouse owner reportedly told a doctor who proposed closing such establishments.

The book is a compelling investigative thriller that intersperses summaries of events with personal case histories and anecdotes. The index patient, the Canadian air steward Gaetan Dugas, is a recurring, near mythical figure, who appears in both book and film almost like a stock villain.

The sections are mostly framed in uncannily prescient quotes from Albert Camus's *The Plague*. Symptoms and illnesses are described in graphic detail. For Shilts, the tipping point in the catastrophe was the film star Rock Hudson's AIDS related death, which brought the topic out into the open. Shilts himself died in 1994, too late to benefit from the antiretroviral treatments that have shaped the course of treatment of the disease since the 1990s.

Roger Spottiswoode's 1993 film narrows the focus of the labyrinthine book to those events seen from the perspective of Don Francis, an epidemiologist at the Centers for Disease Control. The film begins with Francis's work on the containment of the world's first known outbreak of Ebola haemorrhagic fever in central Africa in the late 1970s. Francis ultimately finds his funding application for a project to tackle the AIDS epidemic rejected by the government, and later resigns. Television footage of speeches by Reagan and others underline the film's historical credentials. The closing scenes of the film are footage of a candlelight vigil and march in San Francisco, followed by a montage of images of people with HIV, while Elton John sings. It feels too syrupy at the end of such a gripping story, with such an excellent cast, including my favourite, Lily Tomlin, as the epidemiologist Selma Dritz.

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- Obituary: Selma Dritz (*BMJ* 2008;337:a2192)
- Observations: AIDS at 30 (*BMJ* 2011;342:d3512)
- News: A record 6.6 million patients in poor countries received antiretroviral treatment in 2010 (*BMJ* 2011;342:d3555)

Undoing diagnoses

FROM THE
FRONTLINE
Des Spence



I was labelled a big mouth at school. “Desmond would do better if he occasionally shut up.” Those were the days of honest school reports. Not today: four pages of rambling report cards full of educational jargon. I read them intently to show that I care, even if I find them incomprehensible and meaningless. Education has changed. In the 1980s, BBC at A level would secure a medical school place, but relentless grade inflation means that students today need AAA. The authorities insist that this simply reflects better education. For many this just isn’t plausible, and there are fears that we are devaluing education. We have the same difficulties in medicine.

Society has witnessed relentless diagnosis inflation. We are assured that this reflects better medicine. To many this just isn’t plausible, and there are fears that we are devaluing the profession. Growth areas exist in all medical specialties—hypertension, “cholesterol,” chronic kidney disease, osteoporosis, bipolar illness, and pain syndromes, to name a few. Then there is the overdiagnosis of cancers such as those of the breast and prostate. How has this happened?

The profession has foolishly loosened diagnostic criteria. Our professional organisations engaged in thoughtless and dogmatic disease awareness campaigns to promote underdiagnosis, but never considered inappropriate overdiagnosis. There is pressure from patients and families to make “a diagnosis” because a label is a gateway to services and

support. Patient power has made these requests difficult to resist. At the same time the media report biased, emotive human interest stories to berate the profession. The internet is a medical self labelling gun, devoid of experience or judgment, and choosing a diagnosis is just a click away. These are seemingly unstoppable forces. If you are not already a patient you will be soon. However, many of these labels will eventually be cast down, seen as either an oversimplification or just wrong.

So can we remove a diagnostic label? I am a professional diagnostician but an amateur un-diagnostician. It is hard to persuade patients that they don’t have a “diagnosis” as they clutch their evidence, a printout of an internet self diagnosis questionnaire and comments from an “expert” on an internet forum. It is even difficult to remove a label from those who voluntarily seek undiagnosis, as I found with young adults who question their labels, such as attention-deficit/hyperactivity disorder, Asperger’s syndrome, and polycystic ovary syndrome. How can we remove an overdiagnosis label from a patient with breast cancer? Medical diagnoses are defining and become incorporated in our personalities, with the potential to destroy people’s lives. Labels are sticky and peeling them off will be a messy business.

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The truth hurts

THE BEST
MEDICINE
Liam Farrell



The traditional consultation is a dinosaur; to be fit for purpose it must adapt to an ever changing world. But until now our hands have been tied because the doctor-patient relationship is unequal. Patients can blithely lie to our faces while we are expected to be honest and truthful; it’s like a medical dhimmitude. Well, I’m mad as hell, and I’m not gonna take it anymore.

“Honestly, doc,” said Joe smugly, unaware of my new arrangements. “I don’t smoke.”

“Joe,” I said, giving him one last chance. “Your fingers and teeth are stained the colour of horse manure, and your breath would asphyxiate a hyena. I’m asking you again: do you smoke?”

“Not one puff,” he said defiantly.

The gauntlet had been thrown down, so dauntless the slug-horn to my lips I set, and two burly colonels marched in.

“These gentlemen are from the US embassy,” I said.

“I don’t believe it,” said Joe. “Let me see your badges.”

“Badges? We don’t need no stinking badges,” they said, setting exactly the right tone. They grabbed Joe, pushing him back on the couch. I produced a rag and a large jug of water, placed the rag over his mouth, and started pouring.

“Water boarding is of ancient provenance,” I said conversationally, the sound of gagging an almost musical counterpoint in the background. “It was first used by the Inquisition, you know; those Catholics could teach us a thing or two. Water boarding sounds quite nice, doesn’t it, rather refreshing, like a mountain stream, like surf boarding. Goes to show: names can be misleading. A rose by any other name would smell as sweet, I don’t think so. Now, once again, do you smoke?”

“All right, all right,” he sobbed, after exactly 17 seconds (thereby lasting longer than Christopher Hitchens or the average CIA operative). “I confess, I smoke like a train, and by the way, care assistants aren’t being adequately trained, Donald Trump’s hair is fake, and Bin Laden is in Pakistan. Check out the big house in Abbottabad with all the barbed wire; he’ll be hiding in the bedroom.”

The colonels stood Joe up, saluted smartly, and left, administering one last hefty kick in the kidneys in a graceful American gesture of farewell.

“This is an outrage,” he said, shaken and white faced. “That was torture.”

“I’m rebranding it, Joe,” I said. “That was enhanced consultation.”

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