PERSONAL VIEW **David McCoy**

Commercialisation is bad for public health

The Health and Social Care Bill 2011 is yet to be passed into legislation, but the NHS is already going through a process of considerable transformation. Such is the scale of change that I'm reminded of the time I spent working in the new, democratic South Africa.

The health system of the apartheid regime was abominable. Structurally, the public sector was a fractured mess, divided into multiple departments according to three races and 10 so called tribal homelands. A vast and unregulated network of private providers and insurance schemes added a further layer of fragmentation.

The South African health system was also deeply iniquitous, with world class medical care for an elite minority and a rudimentary service for the majority poor black population. Less well recognised was its inefficiency: a huge oversupply of medical care, overpriced medicines, and more money spent on the healthy than on the sick.

The drivers for this inequity and inefficiency were not just racism and organisational chaos, but also commercialisation and the profiteering and erosion of professional ethics that it spawns. Many within the health system were virtually printing money; shamelessly exploiting both patients and the public purse.

When the African National Congress government came to power in 1994 the required transformation was immense. The fractured public sector had to be integrated and reorganised into a single system with a new set of administrative boundaries. Health workers and other assets had to be redeployed and redistributed. Waste and inefficiency had to be halted by regulation and the reconstruction of a professional and moral ethic.

In the midst of the transformation of the NHS, I am struck by the echoes of South Africa. The reforms have created chaos and disorganisation instead of strengthening the functional integrity of the health system. Competition, private capital, and the financial motive are being encouraged, instead of protecting the public and patients from the corrosive effects of commercialisation. And instead of more money being directed towards benefiting patients, a rising proportion of expenditure will be siphoned out of the NHS as surplus value for private profit or spent on the infrastructure required to "manage competition."

As for public health, when the reforms were first announced, many professionals saw the glint of a silver lining. The government was proposing to elevate the profile of public health by creating a dedicated public health agency and separate public health budgets. The proposal to move certain functions to local government was welcomed as a means of placing greater emphasis on so called upstream determinants of health such as education, housing, diet, leisure, and exercise. Even the notion of the big society chimed with the evidence that social empowerment and solidarity underpin good health.

A rising proportion of expenditure will be siphoned out of the NHS as surplus value for private profit or spent on the infrastructure required to "manage competition"

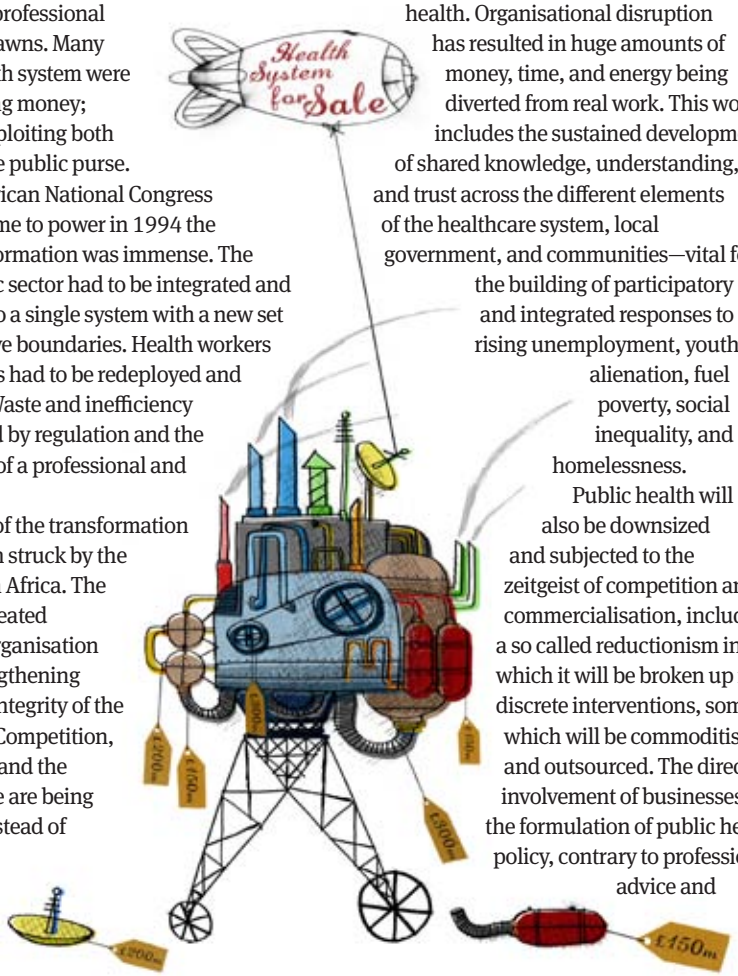
However, there are many threats to public health. Organisational disruption has resulted in huge amounts of money, time, and energy being diverted from real work. This work includes the sustained development of shared knowledge, understanding, and trust across the different elements of the healthcare system, local government, and communities—vital for the building of participatory and integrated responses to rising unemployment, youth alienation, fuel poverty, social inequality, and homelessness.

Public health will also be downsized and subjected to the zeitgeist of competition and commercialisation, including a so called reductionism in which it will be broken up into discrete interventions, some of which will be commoditised and outsourced. The direct involvement of businesses in the formulation of public health policy, contrary to professional advice and evidence, also signals a backward step in the urgent need to regulate the food, alcohol, sugar, and tobacco industries.

The relationship between public health and clinical care may also become more distant. At the moment, local public health and clinical budgets are mostly held together within primary care trusts. But in future, public health and clinical budgets will be spread across different organisations, potentially undermining the public health function of connecting clinical medicine to the social context and physical environment of families and patients. Cancer screening, immunisations, and communicable disease control will become harder and more costly to deliver.

Critics of the reforms are often labelled as being anti-privatisation. But it is commercialisation, the intrinsic tendency for healthcare markets to fail, and the damage that competition does to patient care, trust, and ethical practice that lie at the heart of most objections. At the same time, no one supports a monolithic, command and control public sector. The NHS can be decentralised and incentivised in many ways to ensure innovation, entrepreneurialism, and efficiency. Charities and third sector organisations are all private and vital to the delivery of public health goals.

There would be more resistance from the public health community to the government's reforms were it not that so much effort is being spent chasing the potential silver lining. Some silence is also bred by job insecurity, and possibly by a cynical belief that in spite of overwhelming public support for the core values of the NHS, there is no defence against the steady infiltration of commercialism into all aspects of society. But most of us are concerned to see the erosion of the ethical and cooperative foundations of the NHS and aggrieved by a set of changes that will not deliver efficiency, quality, fairness, or choice.



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doc2doc

How can we know services are commissioned in the best interests of patients? http://bit.ly/z1mCMS

REVIEW OF THE WEEK

Faith in medicine

Despite modern evidence based medicine, many people still take superstitious comfort in the protective or healing powers of objects such as amulets, charms, and votives. **Wendy Moore** enjoys this spellbinding exhibition

Miracles and Charms
Wellcome Collection, London
Until 26 February; closed Mondays; admission free
www.wellcomecollection.org
Rating: ★★★☆

Edward Lovett was a quiet, unassuming man. By day he worked as a clerk in a London bank but at night he scoured the markets, dockyards, and corner shops of the city's east end, hunting for amulets and charms. Among the treasures he brought back to his suburban home were strings of acorns believed to prevent diarrhoea, a bottle of mercury wrapped in chamois leather supposed to be a cure for rheumatism, and a mole's claw meant to ward off arthritis.

Lovett drew a map of London in 1914 meticulously charting his finds, with red dots marking shops where blue glass beads were sold as a cure for bronchitis. He noted that, "every shop of the low class recognised the blue beads as a cure for bronchitis, but not a single shop of the better class knew anything about it, or if they did they did not admit it."

Lovett amassed a collection of more than 1400 magic charms and amulets in common use in working class London at the start of the 20th century, although he refused to admit their potency. Yet when he sent his son to the trenches in 1914 he made him take an amulet for luck.

Whether or not Lovett's 400 charms and tokens collated by the Welcome Collection retain any power to ward off disease, they certainly create a potent and spellbinding exhibition. The collection is shown in conjunction with more than 100 votive paintings from Mexico, in a combined show entitled "Miracles and Charms." The dual exhibition reveals the ubiquity and endurance of faith and superstition in a scientific world.

Lovett eventually sold his London charms to the compulsive collector Henry Wellcome, who had already accumulated a vast store of amulets, tokens, and votives spanning every civilisation since history began. As a pharmaceutical salesman, who introduced medicines in tablet form—trademarked "tabloid"—to Britain with a slick advertising campaign, Wellcome knew full well the importance of faith in medicine.

Now displayed for the first time in almost a century, Lovett's tokens have been carefully selected and tenderly arranged by artist Felicity

INAH

Votive on tin, 2009. The parents of a baby born at 7.5 months promised this retablo to Saint Francis of Assisi in gratitude for the baby's surviving. Right: an amulet

Powell, in a gracefully curving glass covered "table of contents" whose shape echoes the flow of the Thames. Currents of sharks' teeth intermingle with ripples of lucky coins, glass seahorses, and coral hands.

Powell's own artworks, featuring tiny profiles of heads meticulously modelled in white wax on black slate, provide a haunting backdrop to this river of charms. Many of the profiles were created while Powell was undergoing treatment for cancer and they seem to embody an ambiguous point hovering between health and disease. One head is riddled with holes; another is encircled by bees. One grows branches from the neck downwards like a bronchial tree, and another seems to be disintegrating into smoke or water.

Alongside the exhibition, a film shows Powell as she produces the delicate fairy-like heads using her fingers and dental instruments, juxtaposed with images from the magnetic resonance imaging of her own body. Far from putting her faith in any form of superstition during her treatment, she trusted more firmly than ever in the power of medicine, she says. Yet the overlaying of pictures of Lovett's charms on to the scans serves as a reminder of the significance of good fortune in every life.

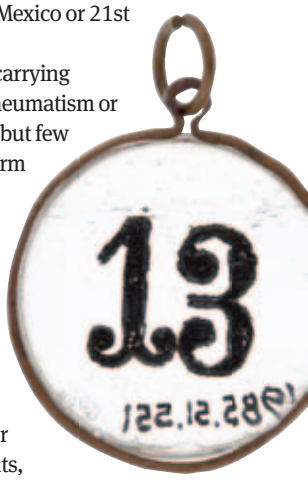
The Mexican votive paintings provide a much cruder, bolder portrayal of the co-existence of faith and medicine. The vivid and simple pictures on tin roof tiles date from the 18th century to the present day, and depict dramatic scenes in which stick shaped people are delivered from illness, accidents, and disasters by the combined forces of saints and science.

The tradition of commissioning paintings as a form of thanksgiving for recovery from disease and disaster began around the time of the Spanish conquest. And just as ancient indigenous customs of sacrifice and giving thanks to pagan gods were subsumed into Catholicism and its plethora of saints, so the pictures have evolved to embrace the advance of medicine.

One of the earliest plaques, from 1748, shows a woman who contracted smallpox while pregnant and gave birth to a baby who survived. At a time when medicine could do nothing to cure smallpox or much else, it made sense to trust in a saintly miracle. Brought right up to date, a picture from 2009 shows a baby born prematurely and kept alive for 52 days in an incubator. The picture makes clear that the child's survival is a tribute to modern science yet the parents still thank Saint Francis of Assisi for their good fortune.

Other pictures portray people undergoing heart surgery or attached to life support machines—all capturing moments in human stories when lives hang in the balance—and are humbling reminders of the vagaries of life whether in 18th century Mexico or 21st century London.

We may scoff today at carrying dried potato to prevent rheumatism or offering thanks to saints, but few of us do not keep some form of talisman or adhere to certain rituals—whether we admit it or not. In an uncertain world, in which science remains fallible and medicine has no panacea, the Wellcome exhibition reminds us that the power of belief—whether in saints, folklore, or just good fortune—retains its deep rooted significance.



PITT RIVERS MUSEUM, UNIVERSITY OF OXFORD.

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Also by Wendy Moore
- Doctors at war (*BMJ* 2011;343:d7606)
- Backing the wrong horse (*BMJ* 2011;343:d7187)
- The Adventures of Roderick Random (*BMJ* 2011;343:d5718)

doc2doc
- Can evidence based doctors believe in God? http://bit.ly/sJIKSK

BETWEEN THE LINES **Theodore Dalrymple**

Malingerers

My late mother suffered a severe rash a few years before she died. She had to wait an age to consult a dermatologist, even privately, and then she saw several in swift succession. All their prescriptions made her rash much worse; the prescriptions were so bad that even stopping them did her no good.

Then she went to a homoeopath, took homoeopathic medicine for a week and recovered almost immediately. The rash melted away as the snow in sunshine. I was very pleased for her, of course, but kept a little corner of my heart free for the irritation that I felt. She, however, was delighted that there were more things in heaven and earth than are dreamt of in most doctors' philosophy.

Anton Chekhov (1860-1904) wrote an anti-homoeopathic story when he was a young man. It is called "Malingerers," and its protagonist is Marfa Petrovna Petchonkin, the rich widow of a general, who has practised homoeopathy as a hobby for 10 years. She is a generous hearted woman who delights in the great success she has as a healer, and often helps her patients financially when they tell her of their difficulties.

She discovers the truth when an impoverished landowner, Zamuhrishen, returns to tell her that she has cured him of the most terrible rheumatism from which he expected shortly to die. He tells her that he wasted a lot of time and money consulting ordinary doctors, who did him "nothing but harm. They drove the disease inwards . . . but to drive out was beyond their science." Zamuhrishen then levels the charge against doctors that has been levelled for centuries: "All they care about is their fees, the brigands."

Zamuhrishen goes down on his knees to Marfa Petrovna.

"I went home from you that Tuesday, looked at the pilules that you gave me then, and wondered what good there could be in them . . . When I took the pilule it was instantaneous! It was as though I had not been ill, or as though it had been lifted off me. My wife looked at me with her eyes starting out of her head and couldn't believe it. 'Why, is it you, Kolya?' 'Yes, it is I,' I said. And we knelt down together before the icon, and fell to praying for our angel: 'Send her, O Lord, all that we are feeling!'"

She was delighted that there were more things in heaven and earth than are dreamt of in most doctors' philosophy

Chekhov: critic of homoeopathy

Marfa Petrovna, who is naturally delighted by the cure she has wrought, says modestly, "It's not my doing. I am only the obedient instrument . . . It's really a miracle. Rheumatism of eight years' standing [cured] by one pilule of scrofuloso!"

Then Zamuhrishen tells Marfa Petrovna of his economic problems. "Poverty weighs on me worse than illness . . . For example, take this . . . It's the time to sow oats, and how is one to sow it if one has no seed?"

Marfa Petrovna is so moved by Zamuhrishen's gratitude that she offers to buy his seed for him; then he asks for a cow, and she promises him that too.

She notices that a little packet of red paper falls from his pocket as he speaks. After he has gone, she examines it, and finds that it contains the very pilules that she has prescribed for him. He has taken none of them, and a doubt begins to enter her mind. This doubt is confirmed when all the patients who follow him praise her curative skill extravagantly—and then ask for economic assistance.

Chekhov draws a short moral: "The deceitfulness of Man!" Yet in the case of my mother . . . well, reality is a complex thing.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

The Illness Narratives

A book by Arthur Kleinman; first published in 1988

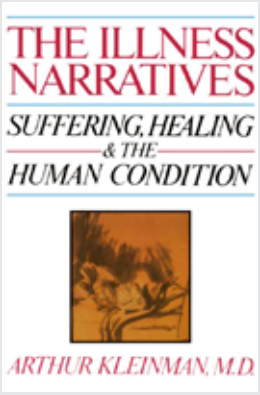
You could be forgiven for thinking this book was written in 2011. An epidemic of chronic pain, a sense of existential doom pervading society, and patients presenting with ever more weird and wonderful neurological symptoms that just don't add up. Not to mention the doctors: deprofessionalised, exhausted, and helpless in the face of a workload increasingly made up of "medically unexplained symptoms."

But this is the 1980s. And Kleinman, a psychiatrist at Harvard Medical School, is drawing on his interviews and research across years of contact with patients in the United States and China.

We meet Howie, a giant of a man, a veteran of the Korean war, crippled by back pain. But the pain is untreatable. Despite four operations and copious painkillers, he remains in constant agony.

We learn of Yen, a teacher rendered immobile from chronic "neurasthenia." Ejected from mainstream life during the Cultural Revolution as an intellectual, she is introverted where she was once assertive, inadequate where she was once capable. No doctor, Eastern or Western, can provide relief from her lethargy, dizziness, and appalling headaches. After a year's leave from her job, she subsists with long term disability status in rural China. Despite its setting, the story is familiar to every general practitioner in Britain.

Then Kleinman turns the spotlight on doctors. The happiest is the one who thinks of medicine primarily as a caring profession. "This is not simply a job," he reflects. "It is a way of life, a moral discipline."



Others are more cynical, more beaten down, with the threat of litigation ever present: "The medical-legal crisis makes all of us run scared—not just of malpractice, but failure to provide fully informed consent about medications." How can he practise medicine with one eye on the patient, the other on "a potential jury trial"? Another is wearied from delivering health in "economic units," bullied by management to get patients through the system ever more quickly. And I thought things were bad now.

What is articulated throughout the book is how physical symptoms are so often a manifestation of a life trajectory. As a patient's personal crises resolve or deepen, so their illness abates or intensifies. Chronic illness, where unexplainable medically, is really a reflection of just how disappointing life is for so many people.

As a GP at the coalface in working class Britain, what I draw most from this book is its permanence. Despite advances in drugs, in therapy, in imaging; despite the profound change in the NHS's political landscape; despite the idea that the world has never been more complex, we find that nothing has really changed since the 1980s. But Michael Balint showed us that symptomatology was much the same in the 1950s. So each generation of doctors that thinks that medicine is different, and the world is different, is fooled: the human condition remains the same.

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FROM THE FRONTLINE **Des Spence**

A call for continuity

Despite the financial storm of 2008 and the billions of pounds used to prop up the banks, nothing much changed in the NHS. But the cold wind of reality now blows through the public sector—cuts are coming. The last government engaged in political health grandstanding, producing some foolish (if not frankly stupid) ideas. Initiatives like walk in centres, NHS Direct call centres, and Darzi centres all largely duplicated existing services. They were wildly expensive too. Compared with general practice consultations, walk in centres cost twice as much (http://bit.ly/xraUyC), some Darzi centres more than seven times as much (www.practicebusiness.co.uk/news/1367/darzi-centres-heralded-as-%93massive-waste-of-money%94-/), and every phone call to NHS Direct cost £25 (http://tgr.ph/cqyrGo). Our energies would be much better spent reorganising the imperfect services we have. Ideas should always come before ideology, and simplifying services is the key to improving function and cost.

These [out of hours] services are addicted to algorithms and proformas that have diminished professional discretion

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The current government is set to dismantle many of these profligate initiatives and, in the spirit of simplicity, here is an idea they might like to consider. NHS Direct presently offers telephone triage for many out of hours services. This triage is a slow affair, often performed from large, distant call centres with little local knowledge. Call handlers take extensive unimportant details, then pass calls on to senior nurses or doctors. These services are addicted to algorithms and proformas that have diminished professional discretion. But a risk averse system is also a functionally useless system, and since GPs opted out of out of hours responsibility in 2004 (a source of irritation to hospital colleagues), the increase in emergency admissions has become "unsustainable" (http://bit.ly/whw9JO). Are these two events related?

Much out of hours activity involves contact with a handful of well known patients who have dependent health seeking behaviour, but centralised triage services fail to appreciate this. Could out of hours telephone triage be passed back to local practices? To make this acceptable to GPs the service might be available only until 12 pm on weekdays, and 5 pm weekends. The number of calls would not be onerous and practices would be encouraged to defer consultations with patients until the following morning. Rotas would be organised locally and might involve extended rotas between practices.

A precedent exists for this type of change, with the successful extended hours initiatives. Any costs would be offset by the huge savings to be made—NHS Direct costs £150m alone. Most importantly, however, this would return local continuity, re-establish gatekeeping for frequent callers, and undoubtedly reduce pressure on out of hours services.

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THE BEST MEDICINE **Liam Farrell**

Big tits

"Big tits," agreed my colleague, enunciating the words with a certain relish, as it's not often we get a chance to say them with a clear conscience. "Massive tits. The biggest tits I've ever seen."

We country general practitioners are close to nature, and we take our responsibilities seriously. There is a bigger picture, so I wrote to Sir David Attenborough with my solution to global warming: "Introduce polar bears to the Antarctic, there are millions of penguins for them to eat."

But while I wait for the great man's reply, local issues remain important, and we've kept a bird table behind the surgery for some years now. Birdseed, mealworms, peanuts; our menu is varied, but the favourite item is lard, and our generosity is now causing its own problems. Give a man a fish and you feed him for a day, goes the proverb; teach a man to fish, and you feed him for a lifetime. Give a bunch of greedy little feckers a free lunch every day, and they'll stuff themselves until their tongues turn blue. We've enabled a handout culture, and reaped the whirlwind of gluttony and sloth.

As we watched, the biggest tit, engorged on saturated fat, flopped off the bird table, plopped on to the ground, and gave a few half-hearted flutters and squawks, before settling back with an apathetic shrug, as if to say: "What can I do, it's not my fault, I hardly eat a thing, it's a hormonal problem."

Health promotion is of prime concern to the diligent clinician, so I picked it up, took it in, checked its lipids, and gave it a lecture on diet and exercise. Fly, I said, be brave, sing your song, leap from tree to tree.

"Introduce polar bears to the Antarctic, there are millions of penguins for them to eat"

"Wheep," said the tit, unenthusiastically. Couldn't you just give me a tablet or something, I could see it thinking.

I opened a window and set it free, to soar, I hoped, into the wide blue yonder. Unfortunately I was on the second floor, and the tit dropped like a stone, stunning a passing climate change denier, before starting to waddle determinedly back towards the bird table.

If we want things to stay as they are, things will have to change, I reckoned. Less fat and carbohydrate, more fibre.

And we're getting a cat.

Liam Farrell is a retired general practitioner, Crossmaglen, County Armagh
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