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The arguments for the NHS's reorganisation do not stand scrutiny: the system does not need mending
Des Spence, p 49

PERSONAL VIEW **Peter Bailey**

Primary care was duped: the bill will wreck the NHS

How have we got into such a mess? How can people who have devoted the whole of their working lives to the principles of the NHS been so compliant, misled, or trampled on (depending on your perspective) in the bungled reorganisations triggered by the Health and Social Care Bill that is now before the upper chamber?

I have worked for the past 12 years as a general practitioner in Health Secretary Andrew Lansley's backyard, setting up a new general practice to serve the people arriving in the green field development of Cambourne (population 9000 and aiming for 11 000). The practice has championed holistic care with the autonomy of the patient, a right to information, and respect for the patient's expertise at the heart of the service.

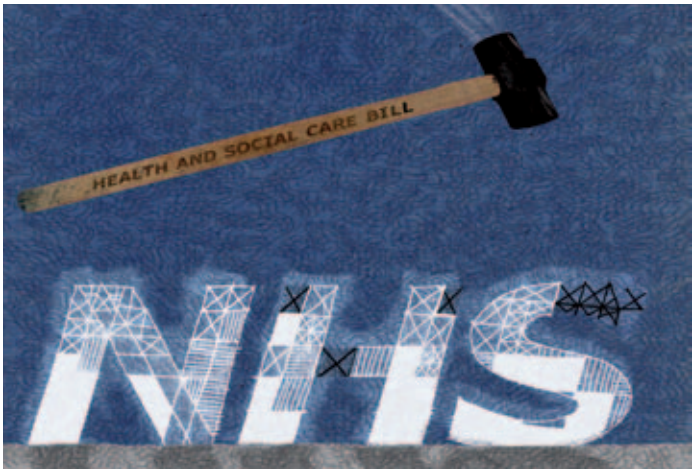
I chaired the local medical committee, and until recently I was vice chair of our emerging primary care consortium as it morphed into a clinical commissioning group.

So I have to put up my hand and say that this mess is my fault. When our primary care trust began to discuss the coming of financial doom in the NHS a few years ago, I felt the shudder in the first class lounge; I saw the whisky glass slide across the polished table and I knew the unsinkable NHS, of which I was so proud, would inevitably founder if we did nothing. I drew graphs and found apposite pictures to entertain my general practitioner colleagues and their practice managers. I attempted to raise awareness of the threats of soaring spending as our population ages, as our scientists become more expensively ingenious, and we all become obese and develop diabetes but survive longer. Something had to be done.

Now we stand baffled in the wreckage like a householder who has recklessly allowed his plausible but incompetent builder to bash out a load bearing wall to improve the view but instead has brought the whole edifice to the point of collapse

Our trust was among the first in the country to recognise that a radical change was needed. Clinicians had to join with managers to improve efficiency. Primary care had to join with secondary care to agree on pathways that served patients better for lower cost. Our trust invited general practitioners to lead, and we responded. We even met Andrew Lansley to explain what we were doing. We drew practices together and published performance figures to ourselves and issued challenges to explain anomalies. We gave our time because we believed in what we were doing. And we were succeeding: costs were falling, and efficiency was improving. Respect between managers and general practitioners and between general practitioners and consultants soared as we learned of each other's expertise.

But then the bill came. We were invited to become so called pathfinders, and we trotted along obediently because we were already leaders. Then we began to understand the proposed legislation. Primary care trusts were to be abolished and pathways were to become illegal, sacrificed to "any willing provider" who would trample across them, waving competition legislation on behalf of their shareholders. The secretary



ROB WHITE

of state was to become a promoter of the provision of health services rather than responsible for them. "Setting the NHS free" was the slogan, but it was really about setting the politicians free. General practitioners were to take over the secretary of state's responsibility and most of the jobs previously done by primary care trusts.

We were being set up. Who among us, even the enthusiasts, had the necessary skills? Who had the extra time needed? How would the complexity of all the new committees, watchdogs, boards, clusters, consortiums, and providers be serviced alongside the day job? Oh, and by the way, we were also to save £20bn (€23.9; $31.6bn) while we were at it.

We had had no warning before the bill that a substantial top down reorganisation of the NHS was to be imposed on us. Indeed, the election manifestos had promised the opposite. As a pathfinder, I went to Downing Street to meet David Cameron, Andrew Lansley, and the chief executive of the English NHS, David Nicholson, and told them that I thought the reforms were unworkable. They listened politely. I wrote to my executive committee colleagues on our commissioning group to urge withdrawal from pathfinder status, but my call to the barricades fell on deaf or reluctant ears.

Our early enthusiasm for protecting the fundamental ethos and values of the NHS led us into collusion with the bill. By the time the professions really understood the bill much of the damage was already done. Many experienced and dedicated primary care trust managers saw what was coming and looked for other jobs; those who remained colluded with the so called reforms in the hope of continuing employment—and the demolition continues.

Now we stand baffled in the wreckage like a householder who has recklessly allowed his plausible but incompetent builder to bash out a load bearing wall to improve the view but instead has brought the whole edifice to the point of collapse. Let us put down the sledgehammer, get rid of the bill, and bring in a structural engineer to stabilise our finest institution.

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The author retired at the end of January.

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BETWEEN THE LINES **Theodore Dalrymple**

Sanitation and antivaccination

Satire on Jenner's vaccination theory by James Gillray, 1802

Few causes in the 19th century were more popular than that of antivaccination. When vaccination, held by many to be medically wrong, was made compulsory, it called forth widespread opposition and even civil disobedience. The antivaccination literature was vast, and among my small collection of the genre is a peculiar book published in 1892 by John Pickering, fellow of the Royal Geographical Society, called *Which? Sanitation and Sanitary Remedies or Vaccination and the Drug Treatment?*

The author starts with an admission that makes him a hostage to fortune: "This book is unsatisfactory to me . . . Book-making is not my *forte*." Among other peculiarities is the following lukewarm endorsement from Florence Nightingale: "You do me too much honour. I much regret my total inability to peruse the proof sheets of your book. I hope [one day] to read your book to which I wish every success."

Pickering takes the standard antidoctor line (soon to be adopted with greater effect by George Bernard Shaw): "To pay the physician for curing disease is, to all intents and purposes to subsidize disease. If the Physician has to live out of disease and its treatment, rest assured that the supply will be equal to the demand."

Doctors will always make work for themselves because, "Statisticians in the Registrar-General's Department say that the science of disease has now culminated in such a crisis that the Register of the names of diseases inimical to life has reached a sum total of one thousand, and that the steady amplification of new diseases is a process that seems capable of infinite variation and extension."

Pickering does not regard the demarcation of disease as a scientific necessity or advance, or a question of fact, because he already knows why people die: lack of sanitation and bad habits.

There is an interesting innovation in the book: an index of phrases or key words. This alone can be read with pleasure for its rhetorical, almost Biblical, sonorities:

"Darkness will reign over the profession, and gross darkness over the people." "Inoculation, Vaccination, Pasteurism, and Kochism, are mummeries all." "The solicitor sickened and had a bad Typhoid experience." "The world is growing weary of the art of medicine." "To refer to tobacco and alcohol as luxuries is a dreadful delusion." (And Pickering doesn't mean by this that they are necessities.) "Vaccination akin to such revelries as those of the devil-worship among the Yezidees."

My favourite phrase in the index, however, is more Charles Pooter (the self important fictional author of the English comic novel *The Diary of a Nobody*) than the Bible: "Sir, I must ask you not to call upon me at the office."

The context is as follows:

> *The teaching of the faculty as to infection is debasing, grovelling, and cruel; it belongs to the age of witchcraft, ogres, vampires, gnomes, oufes, dwergers, nixes, wraiths, and harpies. It is the theory of cowards, spoliasts, recusants, and visionaries. Nay, it is worse even than that, if worse can be. Infection, as understood by public men and society in general, is a subject which is a daily terror, and produces in the minds of thousands of people, educated and uneducated, a sort of chronic hypochondriasis. One gentleman, a merchant, said to me lately, 'Sir, I must ask you not to call upon me at the office: my clerks object to it, seeing as you are so much about Smallpox patients.'*

For Pickering, the prevention and cure of smallpox, as of all other diseases, is fresh air, exercise, vegetables, and refraining from bad habits. *Plus ça change . . .*

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

Churchill: the Struggle for Survival 1940-1965

The diaries of Lord Moran; first published 1966

Winston Leonard Spencer-Churchill was the greatest British statesman of the past century, and perhaps of any century. Yet in the popular imagination he has become little more than a stereotype. Lord Moran's book is remarkable in that it is an intimate portrayal of the doctor-patient relationship, except that the patient happens to be Churchill himself, and the picture that emerges is anything but stereotypical.

In May 1940, when Moran was plain Sir Charles Wilson, the author took on the guardianship of Churchill's health. From the ensuing 25 years a book emerged that is a biography, an autobiography, and a diary. Publication in 1966, so soon after Churchill's death in 1965, was controversial and to some critics a breach of patient confidentiality.

The title is a little disingenuous, but Moran had in mind the years after Churchill's first stroke in 1950. Later editions are split into two volumes and only the second volume now bears the original title. If a "struggle for survival" smacks of hyperbole, the fact that in 1943 in Carthage, modern day Tunisia, Moran saved Churchill's life with sulphonamides does not. North Africa was not the best place to develop pneumonia complicated by cardiac failure and atrial fibrillation, and Moran feared that he was presiding over the death of the prime minister. Other medical experts were consulted, as they were for all Churchill's maladies. Where Moran was sole arbiter, and here the book is most revealing, was in regard to Churchill's fragile psychological state and his fight with the so called black dog, the term Churchill popularised for depression.

EDWIN SAMPSON/DAILY MAIL/REX

Lord Moran announces Churchill's death

Moran was not plucked from obscurity; he was president of the Royal College of Physicians and in the first world war saw active service in the trenches, where he was awarded the Military Cross for his medical achievements. He developed a profound admiration for the ordinary soldier as a consequence, and was a pioneer in recognising what we now call combat stress, formerly disparaged as mere cowardice. He was the author of *The Anatomy of Courage* (1945), highly acclaimed at the time and recently reissued.

No book ostensibly about Churchill should be without humour, and there are many examples. In the rooms of Sir Victor Negus, an ear, nose, and throat specialist of some renown, Churchill is asked about his deafness. "Can you hear a ticking clock in your room," Negus wants to know. "I won't have a ticking clock in my room," Churchill replies.

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FROM THE FRONTLINE **Des Spence**

The NHS bill puts profit before patients

The debate around the health bill has galvanised opinion like never before. Opposition by general practitioners and consultants has been presented as an attempt to preserve self interest. It is not: we have genuine anxiety that changes would irreversibly change the founding and deeply held principles of our NHS. The single greatest fear is the potential for more private medicine. It is proposed that hospital trusts could devote half their time to private practice. Also, commissioning GPs may award lucrative contract services to companies that they might own. This opens an old and explosive question. Is working in the public sector and at the same time working in private medicine a financial conflict of interest?

Fairly or otherwise, it is widely suggested that local consultants have a vested conflict of interest in maintaining waiting lists, because it drives people into highly profitable private practice. Likewise, some suggest that GPs pursue profitable private work during NHS hours to the detriment of their service to NHS patients. These inferences meet with loud howls of indignation about professional integrity. But a current example illustrates the problems of financial conflicts of interest: the Poly Implant Prosthèse scandal. The NHS demands extensive psychological assessments to weigh the potential benefits of breast implant surgery because many women seeking this operation are psychologically vulnerable. Yet in the private sector this is waived; all that is required is a credit card. This unnecessary intervention and now iatrogenic harm is done in the name of profit.

The arguments for the NHS's reorganisation do not stand scrutiny: the system is not broken and does not need mending

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Suggesting that an NHS hospital could devote half its activity to private practice is a very bad idea indeed. Hospital management would become focused on profit. Profit, however, is no basis for a healthcare organisation. To work, paying customers would have always to have more rights than their poor NHS cousins. This not the British way, for wealth should never trump health.

The current economic arguments for the NHS's reorganisation do not stand scrutiny: the system is not broken and does not need mending. Internationally, it is obvious that the world needs more nationalised healthcare, not less. Freeing the NHS to allow more private practice will generate ever more distorting conflicts of interest. These changes are driven by poorly informed political ideology, and their proponents have but a superficial and simplistic understanding of health. The bill is broken, cannot not be mended, and must be withdrawn.

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DRUG TALES AND OTHER STORIES **Robin Ferner**

Interactions

Perhaps interactions between drugs are like interactions between people: mostly inconsequential, occasionally beneficial, sometimes deadly. The principle of cancer chemotherapy before monoclonal antibodies was that the benefits of different anticancer drugs would add up, and their harmful effects would differ. This gave us CHOP and MOPP, FOLFOX and VAMP. The principle could be extended to antihypertensive medicines (*Am J Med* 2009;122:290-300), so we may yet see HAIR (Hypovase (prazosin), Adalat (nifedipine), indapamide, and ramipril) or BALD (bendroflumethiazide, amlodipine, lisinopril, and doxazosin) replacing orthodox monotherapy.

As an aside, the interaction between prescriber and patient is probably at least as important as any interaction between drugs. Only half of patients who start antihypertensive treatment carry on as long as a year. As the National Institute for Health and Clinical Excellence (NICE) puts it, "non-adherence may be the norm (or is at least very common)" (http://bit.ly/AszBEz). NICE recommends that we be frank but non-judgmental, which might be easier if we recall our own rather patchy efforts at finishing a five day course of antibiotics.

But shouldn't we be able to spot those poisonous interactions that kill patients, from clarithromycin cum colchicine to pimozide plus protease inhibitors? There is a combinatorial catch. Remember the conundrum about how many people have to be at a party before there is a better than even chance that two will share a birthday? The answer: 23 (see http://bit.ly/AvwYHY). It's a worry, when you think that there are 253 combinations of 23 people two at a time, even if it does remind you of life as an undergraduate. With five drugs—standard after a myocardial infarct—the number of possible combinations of two drugs is 10; with 10 drugs (common enough these days) it's 45. Checking each possible interaction is hard. Computers should help, but almost everything could interact with almost everything else, so the computer is forever warning of potential dangers. The most ardently safe prescribers find this irritating. You prescribed a diuretic to your poorly controlled hypertensive patient taking an angiotensin converting enzyme inhibitor precisely because you were seeking an "enhanced hypotensive effect." In the United States, half of all family doctors turn off the interaction checking software on their prescribing system (*Arch Intern Med* 2003;163:2625-31). So it's best if we can prescribe the medicines we know about, look up ones we don't, and make sure relations remain cordial.

NICE recommends that we be frank but non-judgmental, which might be easier if we recall our own rather patchy efforts at finishing a five day course of antibiotics

Ike Iheanacho is away.

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