Publicly funded organisations should not be providing private health insurance to their employees
Des Spence, p 47

PERSONAL VIEW **Ciarstan McArdle**

Patients are avoiding follow-up care to get insurance

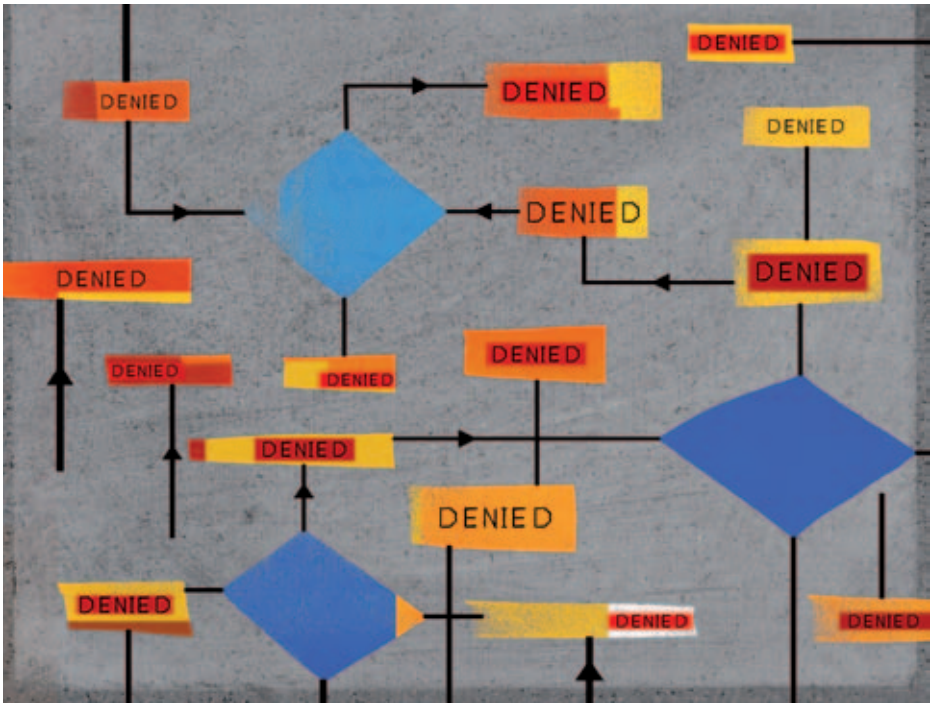
Malignant melanoma is the fifth most commonly diagnosed cancer in the United Kingdom.[1] Incidence has risen fourfold in the past four decades, to 17 cases per 100 000 in 2010, with 85% of patients presenting with localised stage I and II disease.[2] Although the predicted survival rates for these patients at five years is 97% and 81%, the impact of melanoma can be life changing for patients, both personally and financially.[3]

Guidelines on melanoma revised by the British Association of Dermatologists in 2010 recommended up to five years of follow-up after initial diagnosis to examine for evidence of new lesions, recurrence, and potential spread of disease.[4] However, lately in my plastic surgery unit we have seen an alarming rise in the number of patients electing to withdraw from regular review because of difficulties in trying to secure insurance. Patients who do not attend follow-up or fail to self examine risk missing something new or suspicious, especially patients who have had melanomas removed in areas that are difficult to self examine.

Some insurers class follow-up as ongoing care or treatment and can refuse to provide cover to applicants who are receiving such so called ongoing treatment. Even though the predicted risk of recurrence after a localised primary stage I or II melanoma is low, at 2.8% at five years and 3.6% at 10 years,[3] patients either struggle to get medical insurance to cover them or the premium can be as much as four times more expensive.

The Association of British Insurers issues no guidelines for companies to refer to when considering providing insurance for patients with malignant melanoma. Each company determines the risk-benefit ratio for insuring patients. When asked by telephone, seven of the 10 leading British companies that provide medical insurance in the UK told me that they would decline applications from anyone with a pre-existing medical condition, including melanoma, that had been diagnosed within five years of application. They considered the grade and staging of melanoma irrelevant.

Two of the three remaining companies were unwilling to provide insurance for any pre-existing medical condition diagnosed, treated, or receiving ongoing treatment within five years before the application for insurance. These companies considered outpatient follow-up review for people diagnosed with melanoma to be "ongoing treatment." Insurance would be provided only if applicants remained free of disease for the first two years of the policy. One company did not provide information on its policies on providing insurance, citing data protection rules.



ROB WHITE

Insurance companies considered outpatient follow-up review for people diagnosed with melanoma to be "ongoing treatment"

An independent online insurance company with a special interest in coverage for people with pre-existing medical conditions would expect patients with low grade stage I disease to pay three to five times more for insurance than someone without pre-existing medical conditions. Patients diagnosed as having melanoma with stage IB or II disease would initially be refused insurance for up to two years and could then expect to pay as much as twice the annual rate for insurance for a period of five to seven years. Thereafter, patients can again expect to pay above the expected annual price for insurance. Patients with stage IIB or IIC disease diagnosed within the past year would not be provided with cover for two to four years.

The British health insurance industry generated revenue of £3.6bn (€4.47bn; $5.7bn) in 2010.[5] Statistics from the Association of British Insurers show that 3.3 million people bought private medical insurance covering 5.8 million people in the UK in 2010. But a diagnosis of melanoma can have huge financial implications for patients trying to secure medical insurance or life assurance for the future.

Patients with stage I and II disease have similar life expectancy to the average fit and well patient and should pay a similar price for insurance premiums. The insurance industry needs an overhaul, and companies should engage more with clinicians to provide medical advice on conditions such as melanoma.

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References are in the version on bmj.com.

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BETWEEN THE LINES **Theodore Dalrymple**

A keeper of snails

Anyone who spends his or her time among old books, as I now do, must be familiar with the phenomenon of the pedant who has pounced gleefully on the one orthographical error, underlined it in pencil, and put an exclamation mark in the margin as if this single error cancelled out all that the author has to say in the rest of the book. Indeed, one has the impression that such a person has read the entire book with the express purpose of finding such an error; for him or her there is no joy quite like it.

I shall not here dilate on the psychology of pedantry, for it does not appear as a disorder in either the *Diagnostic and Statistical Manual of Mental Disorders* or the *International Classification of Diseases* and is therefore of no medical interest; suffice it to say that many of us have an inner pedant struggling to get out and mark up our books in a similar fashion. Mine very nearly escaped recently while reading a short story by Patricia Highsmith (1921-95) called "The Quest for *Blank Claveringi*" in a collection called simply *Eleven*.

Highsmith was a writer who revealed the horror that often (or is it always?) lurks behind the facade of ordinary life. She had alcohol dependency, said she preferred animals to people, and kept pet snails, creatures not particularly known for reciprocating affection. Snails feature in her story, but they are not the kind of snails that were kept by Highsmith. Rather, they are giant, man eating snails that inhabit a remote and uninhabited Pacific island.

ULF ANDERSEN/GETTY IMAGES

Highsmith had alcohol dependency, said she preferred animals to people, and kept pet snails, creatures not particularly known for reciprocating affection

Professor Clavinger, a zoologist, wants to immortalise himself by finding this species, which he thinks will be named after him. An equally obsessed doctor tries to discourage him, apparently to save him from wasting his time but in reality to save his life. In due course Clavinger is duly eaten by his great discovery—a denouement that perhaps serves as a metonym for humanity's Promethean bargain with expanding knowledge and technical capacity?

In the title, and throughout the story, the giant snail is referred to as *Blank Claveringi* (the professor cannot decide what genus it belongs to). But surely it should be *claveringi* rather than *Claveringi*? This tiny point ran through my mind like one of those irritating tunes you can't get out of your head; but I cannot say that it was entirely without pleasure that I alighted on it.

Another story in the book, "When the Fleet was in at Mobile," has a splendid opening sentence: "With the bottle of chloroform in her hand, Geraldine stared at the man asleep on the back porch."

One knows that there will not be a happy ending to this story. However, the man is Geraldine's jealous husband, who thinks that she is having an affair with any man with whom she has the slightest contact and who is violent towards her. She experiences killing him as a liberation.

But unbeknown to her as she flees the marital home, her husband has survived her chloroform attack. At the end of the story she is apprehended by the police, who do not charge her with attempted murder but merely as a missing person to be returned to her husband.

This is a brilliant condensation of a sordid and tragic situation that I met many times in clinical practice.

Theodore Dalrymple is a writer and retired doctor

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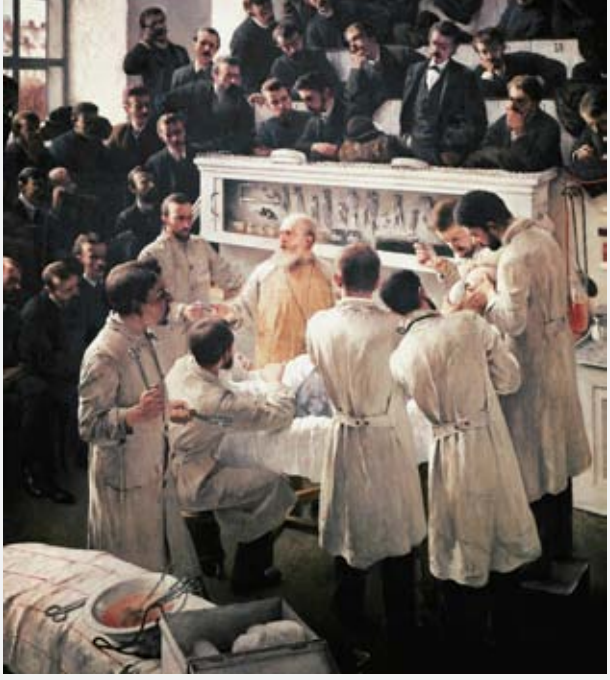

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MEDICAL CLASSICS

The Billroth Lecture By Adalbert Franz Seligmann; painted in 1889

A casualty of the hegemony of the English language is our distancing from the primacy of Austro-Germanic leadership in medical research, practice, and education in the second half of the 19th and the early 20th centuries. Nearly every field of medical practice continues to benefit from the imagination, energy, and systematic inquiry of giants such as Koch, Kraepelin, Virchow, Rokitansky, Semmelweiss, Freud, and countless others. We may also underestimate their impact on education, in particular through the 1910 Flexner report in the United States, which profoundly influenced teaching in medical schools in the US and further afield. Flexner drew heavily on the scientific and innovative aspects of German medical education and in particular the approach of the great Austrian surgeon, Theodor Billroth.[1]

This famous painting illustrates and celebrates the central role of this charismatic figure in Viennese medicine. Our eye is immediately drawn to the brightly lit figure of the great surgeon, who was the pioneer of countless operations, some of which continue in virtually unchanged form, particularly the Billroth gastrectomies. His pose is imperial, and the anxious attention of the inner circle of assistants is almost palpable as they direct their eyes to the focal point of his gesturing arm. The gleaming instruments are arranged neatly in cases, suggestive of his highly organised surgical protocols. From the artist's notes, we know that the operation is a neurotomy for trigeminal analgesia. The advances of sepsis and anaesthesia are both illustrated, with the patient presumably receiving Billroth's favoured combination of alcohol, chloroform, and ether through the face mask.

The title in German uses a more adjectival form of his name, *Billroth'sche*, suggesting a wider familiarity with Billroth and his methods among the Viennese public than we would expect with surgeons today. His renown arose not only from his professional ingenuity but also from his close friendship with Johannes Brahms: Billroth hosted the premiere of many of Brahms's chamber works in his home and was the dedicatee of two of his string quartets.

But we have also progressed in medical education and sensibilities as well since this time: the onlookers are not just medical students but a range of public figures, including the Duke of Bavaria, who frequently joined the tiered benches overlooking the operating table in the world famous *Allgemeines Krankenhaus* (Vienna General Hospital). And if modern medical art would also be less likely to consign the patient to such a passive role, we can still only be grateful to Seligmann for such a vivid and thought provoking image—that transcends all linguistic barriers—of one of the greatest trailblazers in modern medicine.

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FROM THE FRONTLINE **Des Spence**

All in it together?

I know lots of people in Orkney—the barman, farmer, doctor, labourer, creeler, council official, cleaner, lawyer, policeman, and MP—because I went to school with them. Orkney has no private schools, just a large comprehensive in Kirkwall, where everyone went. So no one gets too self important in Orkney because we all know about each other.

And despite its terrible weather and relative rural poverty Orkney is one of the happiest places to live.[1] A community educated together stays together. Private schools and faith schools are a social folly, creating a divided society. Comprehensive schooling may not deliver the best academic grades, but in my view the children get a better education. Social cohesion can occur only when everyone uses public services, so everyone has a vested interest in making them work.

The BBC is a public service. The pay of its top executives is heavily criticised, with huge pensions and redundancy payouts of as much as £670 000 each, more than what many people earn in a lifetime.[2 3]

It is unacceptable that a public institution, charity, or medical organisation should pay for private medical cover (or private education)

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The reasoning is that these payouts are in line with executives in the private sector, but they are simply unjustifiable in either sector. Neither group are entrepreneurs or wealth creators. In these institutions and corporations it simply seems like there are cushy jobs for the boys and girls of certain social backgrounds and the right accent. This is an establishment blind to the reality of common people, where the minimum wage is just £6.19 an hour, an annual income of some £13 000.[4]

Another revelation is that 574 senior BBC executives receive private healthcare, paid for out of the public purse.[3] Our public institutions need to support each other and lead by example. Are key opinion leaders and public servants too precious to mix with everyone else? Further, this essentially suggests that a public institution believes that the NHS is a second rate service. When influential people do not use the NHS they have no vested interest in making it work. The actions of a privileged elite are eroding the broader values of our society.

Which other publicly funded bodies provide private medical insurance through the public coffers? Do senior civil servants use the NHS? The General Medical Council provides some of its staff with private insurance,[5] and I call on it to show solidarity with the NHS and ordinary doctors by cancelling this. It is unacceptable that a public institution, charity, or medical organisation should pay for private medical cover (or private education). We won't get a cohesive society merely by paying lip service to being "all in it together" but by actively demonstrating this.

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References are in the version on bmj.com.

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THE BIGGER PICTURE **Mary E Black**

Lest we forget

Did it all really happen? As I travelled happily by a strangely prompt and friendly London Underground and walked by beds of blooming wild flowers at the Olympic Park en route to basketball semifinals, I felt that all was right with the world. The thought of the collective hard work and goodwill within the NHS during the years of preparation was uplifting.

At the opening ceremony we beamed with pride at the sheer, weird genius of the letters N, H, and S spelled out in lit-up hospital beds. It's odd to think then that this beloved institution is only 64 years old, less than a human lifetime.

Head bent to a cold wind blowing limp autumn leaves along London streets, these euphoric memories seem a lifetime away. I look ahead and shiver. And not just for the bleak midwinter but for the world's gloomy future: a bloated industrial-military complex, the widening Great Pacific garbage patch, and continuing world hunger. Lonely, thin polar bears afloat on shrinking ice floes distress me. Get me out of here: I want to go back to women's beach volleyball.

Another golden time I would go back to is just after the second world war. Having razed much of civilisation, humans set to to make things right. Those were heady times, when great global institutions were built. Warring countries sat down together at the United Nations. International human rights laws were passed that would never see the light of day now. And we got our national health service, free at point of delivery and funded by general taxation.

My grandfather served as a medical officer in the the first world war and was gassed. He limped on afterwards, serving the poor of Greenock, often without payment, till he coughed himself to an early grave. I believe that both my parents, as many other postwar NHS doctors, were married to their jobs because they had experienced the alternative, when the world was set on destruction and many poor people had no healthcare. We later generations understand this only in the abstract. I have had sleepless nights at the thought that we may forget the enlightened horse trading that led to the birth of the NHS and that we may let it slip away.

I have had sleepless nights at the thought that we may forget the enlightened horse trading that led to the birth of the NHS and that we may let it slip away

Human beings are supposed to collaborative and to rise above individual needs. Collective endeavour feeds our souls. Beset by a rising tide of social inequalities, we need to work together to make this world right. We know we can. We've proved we can. But will we?

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