NO HOLDS BARRED Margaret McCartney

Forever indebted to pharma

As a student 20 years ago I failed to realise that the sandwiches at the lunchtime meetings were a lure, organised by the suited rep hovering at the back. Big pharma was ingrained throughout postgraduate education, and this continues even now. Every week I get invitations to local hotels with the offer of a buffet meal and a free talk from a local consultant, all organised and paid for by the drug industry.

But we know that doctors' exposure to pharma sponsored literature is associated with higher prescribing frequency, higher cost, or lower prescribing quality.[1] The money that industry spends on wooing doctors with free education is, of course, calculated to yield profitable returns.

Paying our own way would enable doctors to regain control. In recent years I've attended meetings in national conference venues that were packed with sponsors, such as device manufacturers or drug and clinical test companies. I've also attended conferences in smaller halls in the past year that had no commercial sponsorship; the venues were perhaps not as glamorous, but the costs were much the same. It's rare, but it's certainly possible.

A colleague told me that attendance plummeted when she decided to end the pharma sponsorship of an annual educational event and to charge doctors £40 each instead. Are we so culturally attached to free education that we don't care about the price? A £40 fee is hardly robbery, and free education is not worth the unwritten debt to sponsors.

At these events it's also often unclear what vested interests speakers have until they flash a slide at the start of their talks. We should insist on seeing a full declaration of potential conflicts and sponsors before we sign up.

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By deciding what we need and what we would like to learn, we can set our own agenda rather than be the recipients of someone else's—for example, the pressing problems modern general practice faces from polypharmacy, multimorbidity, when to stop drugs and how to rationalise them, and how best to manage frailty.

Taking back our educational agenda means that we can insist on value for money. Like jumping into ice cold water—as I do when I swim in the lochs and seas of Scotland—paying for education may at first feel uncomfortable. But it takes only a few seconds to feel good, and the post-swim glow lasts and lasts.

Doctors all want to advocate for patients, to be trusted and relied on. But the independence that this requires comes at a price. We need to get doctors' education under our control; there is no other option. We are going to have to start paying our own way.

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IF I RULED THE NHS Stephen Gillam

Don't mention the P word

ELECTION 2015

If I ran the NHS I would begin by abandoning all "pathways." Many of medicine's woes are self inflicted. Technological advances have driven a degree of subspecialisation that is insupportable. Patients often attest to the bewildering fragmentation of their care. The sticking plaster, often designed to remedy this after the event, is the care pathway.

One patient recently explained to me how her elderly mother's discharge was delayed not for lack of facilities at home but because four different people needed to be involved in signing off her "discharge pathway." Of course, some necessarily complex care requires intricate detailing, but the proliferation of overlapping roles is a driver of inefficiency.

My next bonfire would consume all referral protocols. Many outpatient departments can nowadays be accessed only using their own particular multi-page pro forma. A mole from a nearby transient ischaemic attack clinic reports that, notwithstanding the pro forma, only a third of cases referred to her bear any more resemblance to a transient ischaemic attack than her Saturday morning hangover. Nevertheless, each referral is then legitimised with carotid Doppler scan, cranial magnetic resonance imaging, and other investigations costing over £1000.

We have colluded in evolving services that are unfit for purpose

A relatively recent development egregiously combines these perils. Gone are the days when you referred to a single expert. Now we are faced with a panoply of new rapid access or community based clinics. These too come with their own individual referral pro formas with no space for anything other than mostly trivial box ticking. (The first question on the form for the "rapid access palpitations clinic" I have just completed humorously asks whether the patient has palpitations.)

These clinics have often been established on the basis of whim rather than any evidence of efficiency. Appeals for activity data, evaluation, or audit generally fall on deaf ears. Even our clinical commissioning group seems to have little interest in robust evaluation, assuming in the traditional but erroneous way that "community based" equals cheaper and more patient friendly.

If the gap in effectiveness between research evidence and guideline is often great, the gap between guideline and practical pathway is greater. I'm not really against all pathways, protocols, or even community clinics as a matter of course, but they are a legitimate focus for health services research. These are only the symptoms of a deeper malaise. Medical students are trained to manage chronic disease to a high level. Yet the generalist skills needed to manage today's multimorbidity are swiftly eroded, whether in general practice or hospital medicine. This is what I would really seek to reverse, for we have colluded in evolving services that are unfit for purpose.

I should like to finish on a positive note by offering to pilot my marvellous new invention: the single narrative referral letter with no boxes to tick. No, the SNRL doesn't come with eight pages of guidance on how to write one. There's even a paragraph for some personal detail—but does anyone read that nowadays?

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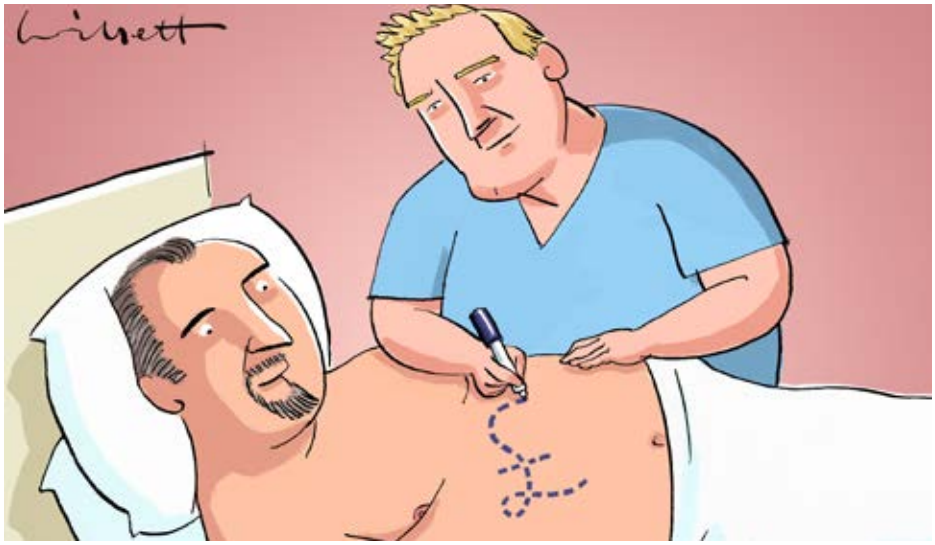
Private practice is unethical: give it up

Profit rather than need is a poor driver of clinical decision making, writes **John Dean**. Private practice also directly affects the care that NHS patients receive, he says—which is why he's stopped doing it

Ask any smoker: the last person they want to be with when lighting up is someone who has just quit. I sense a similar discomfort among some of my colleagues now that I have given up private medical practice. Like a lapsed Catholic shunned by the priesthood, I have become an apostate.

I have always been ambivalent about private practice, and I had become increasingly uncomfortable about my own involvement. I realised that, in all conscience, I could not go on with it. No matter how high I set my own moral and ethical standards I could not escape the fact that I was involved in a business where the conduct of some was so venal, it bordered on criminal—the greedy preying on the needy.

The business of medicine and the practice of medicine are at odds. Private medicine encourages doctors to make decisions on the basis of profit rather than need. When confronted with a choice between two treatment pathways in equipoise—one that earns the doctor no money and the other with a fat fee attached—that conflict is stark. I cannot say, with hand on heart, that I have never chosen the second option.



It is difficult to justify subjecting private patients to unnecessary tests and treatments if you avoid doing the same to NHS patients. To ease the stress of this cognitive dissonance you have to operate the same system in both wings of your practice

Money is at the root of it all

So why did I do it? To begin with, I decided that I needed the money to renovate the house, educate the children, and so on. And I was sure that I could keep the private work separate from my NHS work. I saw private patients after hours and slotted in operations in my free time. But it became increasingly difficult to keep the lid on the private jar as the contents expanded, and some spillage was inevitable.

I wasn't so much earning a living as earning an earning. Of course, the rewards from private practice were not entirely financial; I could spend more time with these patients, and I met some colourful characters and made good friends, which would not have happened if I had restricted myself exclusively to NHS work. But the inescapable fact is that money was at the root of it all. This is strange, because I never hankered after a Maserati car or a chalet in the Swiss Alps. And I'm not attracted by the promise of "fine dining"—I'm more of a chicken balti man.

Private work also has direct adverse effects on the NHS. A consultant cannot be in two places at once, so time spent in the private sector deprives the NHS of a valuable resource. Private medicine is a lonely place; you do not have the support of a team, as you have in the NHS. It is also difficult to discuss problems with colleagues—after all, the problems are yours, and you are being paid to sort them out. In the private sector your NHS colleagues are usually your competitors.

And, let's face it: the whole business is largely a con. Patients think that paying must mean higher quality medicine, but—like paying more for shampoo with added vitamins—the promise is far greater than the reality. Rich and famous people may use private facilities to shelter from the public gaze; for most "ordinary" private patients, though, the main advantage is simply to jump the NHS queue. Private hospitals are like five star hotels, but for the most part they are no place to be if you are really sick.

Cognitive dissonance

The most pernicious aspect of private medical work, however, is the indirect effect it has on a consultant's NHS practice. It is difficult to justify subjecting private patients to unnecessary tests and treatments if you avoid doing the same to NHS patients. So, to ease the stress of this cognitive dissonance, you have to operate the same system in both wings of your practice. Also, private practice creates a perverse incentive to increase your NHS waiting times—after all, the longer they are, the more private practice will accrue. Hence, specialties with short waiting times, such as oncology, offer little private work. Jealousy over private income is a major source of conflict between consultants in many hospitals.

I know what some will be thinking: what's wrong with doing extra work in your own free time? If I had done a paper round or taken a Saturday job, wouldn't that have been the same? Well, the work might have worn me out, but there would be no other conflict with my main business.

I don't miss private practice. The release of the burden is liberating. And I find that the time I have gained is much more valuable to me than the money was. Is it a crass hypocrisy, though, for me to sit atop the pile of money I earned and pretend to have the moral high ground? Maybe, but I wish I hadn't done it. Perhaps it would have been easier if I had not been allowed to. Perhaps the rulers of healthcare should draw an uncrossable line between private and public medicine and tell doctors to choose: namely, that they cannot work on both sides of the divide.

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