Evidence not ideology

The BMJ should take a position on the evidence about privatisation

Editor—The argument is that the BMJ shouldn’t have a position on the privatisation of health care and the NHS, but it should simply be a forum to allow the issues to be debated.1

But neutrality on this issue is wrong. It means abdicating the responsibility of a scientific publication to weigh evidence and argument based on evidence. A very large accumulated body of evidence underpins the establishment and development of a publicly owned and operated health system in the UK; evidence that advocates of its abandonment have yet to supplant with valid evidence of their own.

The fairest way of funding health services is through a progressive tax based system. The alternatives—social insurance services, through a progressive tax based abandonment have yet to supplant with the establishment and development of a publicly owned and operated health system in the UK, evidence that advocates of its abandonment have yet to supplant with valid evidence of their own. Accumulated body of evidence underpins argument based on evidence. A very large scientific publication to weigh evidence and means abdicating the responsibility of a scientific publication to weigh evidence and argument based on evidence. A very large accumulated body of evidence underpins the establishment and development of a publicly owned and operated health system in the UK, evidence that advocates of its abandonment have yet to supplant with valid evidence of their own.

Evidence about privatisation

The claim that private provision leads to greater efficiency is refuted by evidence from both the United States, where it is most general, and now from this country, by the example of the independent sector treatment centres. The claim that it doesn’t matter who provides care is also refuted by the evidence of the past 25 years of privatisation in the UK. Health secretary Patricia Hewitt’s claim that the outsourcing of elective care will come to no more than 1% of the NHS budget is evasive and wrong. It is designed to defuse the fear that it will be more, but the claim flies in the face of all economic logic, recent history, and common sense. The privatisation of clinical provision now being pushed through is no different. It is in the nature of private companies never to be content with a given market share.

Allyson M Pollock professor, health policy and health service research School of Public Policy, University College London, London WC1H 9QW allyson.pollock@ucl.ac.uk

Competing interests: None declared.

1 Godlee F. Evidence not ideology [Editor’s choice]. BMJ 2005;331. (8 October.)

No evidence is without ideology

Editor—Godlee asks for evidence without ideology, as though it were possible either to discover or use evidence without ideology of some kind. Scientific evidence is derived from hypotheses conceived within an ideology—that is, a set of prior assumptions about the real world, established by previous evidence, by faith, or by both. New evidence can then be produced by testing hypotheses derived from those assumptions against reality. The validity of competing hypotheses, including those macro-hypotheses about the world or society we call ideologies, depends on their explanatory and predictive power in the real world.

About the private finance initiative and the Blair government’s disintegration of the NHS into a competitive market led by consumer wants rather than by national health needs, nobody has published more evidence than Pollock. For the editor of the BMJ to dismiss this as led by ideology is an impertinence. Without exception, every paper published by the BMJ starts from ideological assumptions of some kind. That the editor’s assumptions apparently coincide with those of currently fashionable and conventional opinion does not change their ideological nature. Readers can make their own judgments as to which ideology has most explanatory and predictive power, either experimentally or in the more chaotic real world of practice, which in the absence of pilot projects is all we have to go on in assessing the consequences of marketisation.

This is a deadly serious business. Asked to describe the nature of the corporate state in the 1920s, before the full consequences of fascism were understood by comfortable people outside Italy, Mussolini answered that in his state the worlds of government and business would become one and indivisible. Godlee should consider how far we have already travelled along that road, and then reconsider the ethics of neutrality in such a situation. At the birth of the NHS, the BMJ had a role of which its later editors were frankly ashamed. Today, when the NHS is being buried alive, has it lost the power of speech?

Julian Tudor Hart retired general practitioner Primary Care Group, Swansea University Clinical School, Swansea SA2 8PP julian@tudorhart.freeserve.co.uk

Competing interests: None declared.

1 Godlee F. Evidence not ideology [Editor’s choice]. BMJ 2005;331. (8 October.)

The NHS is still working

Editor—I agree with Hart’s contention that all evidence is conceived and perceived through an “ideology” (previous letter). Reading Marx made this clear to me, but other philosophers might use the more acceptable phrase “theory of knowledge.” The term “ideology” is currently (mis)used to imply a left wing or right wing political mindset that somehow prevents people from seeing the “objective evidence” for what it is—with the corollary (to which Godlee subscribes) that those “neutrals” unconcerned by ideology could somehow be the more objective.

My political ideology is socialist. I prefer the NHS to the US system. But I believe that other systems—for example, the Swedish system—have some better features.

964 BMJ VOLUME 331 22 OCTOBER 2005 bmj.com
If the NHS contracts for secondary care—for example, cataract surgery—through self employed doctors in wholly owned secondary care doctor cooperatives, or private hospitals, how shall we describe it? With regard to privatisation or subcontracting, the general practitioner subcontractor model was a very efficient saving grace of the state run NHS. I prefer that "socialised health care" should proceed in fair competition in the mixed economy of a free society, rather than the Stalinist alternative. I am certain that we are succeeding at it—which is the main reason why the new right is still scratching around for alternatives. It is still working.

L S Lewis general practitioner
Surgery, Newport, Pembrokeshire SA42 0TJ
sam@garthnewydd自由贸易zone.co.uk
Competing interests: LSI, is a GP contracted under nGMS to the UK state NHS.

1 Godlee F. Evidence not ideology [Editor’s choice]. BMJ 2005;331:351. (8 October.)

Time for OfHealth

Editor—Many public utilities in the United Kingdom have independent regulators to see that commercial interests and unfair pricing do not disadvantage the public. Providers of these public utilities have to submit detailed financial information to the regulator. The regulator may intervene if it thinks that the proposed pricing of services by the provider is unreasonable.

At present the UK does not have an independent regulator of healthcare reform. Governments may undertake reforms on the basis of market principles that run counter to the widely held principle of collaboration between NHS professionals. Yet the consequences of ill judged reform of the NHS may inflict long term damage on the delivery of health care to its citizens.

The shortcomings of the private finance initiative—such as the lack of flexibility in adapting hospital design to changing healthcare needs, highlighted by Ann and McKee in their editorial,1 shortage of hospital capacity,1 no independent audit of the reform process, and excessive length of PFI contracts to encourage commercial financing, are persuasive arguments for an independent regulator of NHS reform.

The key tests applied by the regulator might be equity of access to care irrespective of means; collaboration between healthcare professionals, managers, and patients; financial prudence and transparency; proof of principle from pilot studies; and a clearly defined audit process to assess the clinical and economic impact of reform on health-care delivery and outcomes. If these golden rules were met, the UK government would be more likely to carry the support of the public and NHS professionals to meet effectively the healthcare challenges of the 21st century.

Ian H Kunkler consultant in clinical oncology
Western General Hospital, Edinburgh EH12 9JAR
i.kunkler@et.ac.uk

Competing interests: None declared.

1 Ann RA, McKee M. Is the private finance initiative dead? BMJ 2005;331:792-3. (8 October.)

Do GPs deserve their pay rise?

Of course successful hard work deserves reward

Editor—Timmins’ article on general practitioners’ recent pay rise voiced the common view that if targets are exceeded then they were undoubtedly too easy.

Since 1997 funding for the hospital sector has grown quickly, with general practice funding becoming a successively smaller proportion of NHS spending. During this time, hospitals have been adept at transferring responsibility for chronic disease management and follow-ups to general practice, with no corresponding transfer of funding. Now, when general practice has the opportunity to receive funding for this work, under a far more stringent and detailed performance management framework than has ever been accepted elsewhere in the NHS, the idea that success in this framework might be due to good organisation, teamwork, and hard work is simply not considered.

A further misconception is that the relation between this funding for additional work and pay rises for general practitioners is simple. Practices have invested (often heavily) in additional staff in the knowledge that funding would only be forthcoming if the targets were reached. This degree of personal business risk taking is almost unknown elsewhere in the NHS, or in the workplaces of the health economists quoted.

The idea of giving groups of clinicians extensive control over budgets and team-working, carrying personal financial risk but also the possibility of reward for success, is neither new or unique to British general practice. It lies behind the success of the Kaiser Permanente health maintenance organisation in the US. Many NHS managers visited California to see Kaiser Permanente, but few if any subsequently seem to have recognised or valued the same features in British general practice.

So, why not be a bit more upbeat about how well at least one part of the NHS can perform in a framework of 146 separate targets, if allowed modest but adequate funding support?

Graham Wheatley general practitioner
Munro Medical Centre, West Elloe Avenue, Spalding, Lincolnshire PE11 2BY
w1@mac.com

Competing interests: None declared.

1 Timmins N Do GPs deserve their recent pay rise? BMJ 2005;331:800. (8 October.)

What do GPs earn?

Editor—Many people (non-general practitioners) must surely be asking, “So, how much do GPs earn?” when considering whether general practitioners deserve their recent pay rise.

The answer is quite a lot. Full time general practitioner principals in well organised practices would be disappointed to earn less than £100 000 a year for 2004-5. The range can be considerable, given the differing circumstances in which doctors work; for full time principals it is £80 000-£120 000. For 2006-7 the quality points will be worth on average (depending on practice size) £120 per point, compared with £70 this year.

Don’t forget, general practitioners have dropped the 24 hour responsibility and so are now working something in the region of a 45-55 hour week.

Denis Colligan general practitioner
Whitley Road Medical Centre, Collyhurst, Manchester M40 7QH
deniscohill@nhs.net

Competing interests: None declared.

1 Timmins N Do GPs deserve their recent pay rise? BMJ 2005;331:800. (8 October.)

Do chief executives deserve their pay rises?

Editor—The question whether chief executive officers (CEOs) in both the NHS and the private sector deserve their pay rises is not asked and does not generate articles describing detailed and arbitrary formulas and parameters for pay increases as it was for general practitioners.1 How many grossly inflated severance packages have we seen in recent years given to people, self important people, who have not infrequently received knighthoods for their financial prowess, but who have also presided, with their great acumen, over the failures of several important companies?

Yet general practitioners who see 40 plus patients a day and have to tease out the minor from the major—and heaven help them if something goes wrong—for which time that volume is a high certainty at some point—are subject to this thicket of performance parameters. Marx once said that he who controls the means of production controls the means of mental production in a society—that is, the ideology. One thing is clear: doctors are certainly not in control of the ideology related to their own profession. When a doctor fails he or she is subject to scrutiny and discipline and possibly worse. When a CEO fails, it is not failure, and even if it is, well there’s
always the next trust or company to administer . . . and maybe even ruin. But then there's that richly deserved severance package.

Richard Rosin consultant psychiatrist
VA Medical Center Puget Sound, Seattle, WA 98168, USA
richard.rosin@med.va.gov

Competing interests: None declared.

IBM is replacing EBM

Editor—Income based medicine (IBM) is replacing evidence based medicine (EBM).1 When general practitioners are more concerned about whether the blood pressure is down to 140 systolic than whether the acute scatica has subsided, a serious divergence develops between the priorities of the patient and the doctor. The government pays the piper, but we who pay the patient and the doctor. The government pays the piper, but we who pay the government can't call the tune.

G H Hall retired physician
Exeter EX1 2HW
h.2@which.net

Competing interests: None declared.

Students need education fit for professional and public life

Editor—No one could reasonably argue with Wass that medical schools need to convince the public that they are producing doctors with the correct competencies at an appropriate standard.1 A national body could even usefully generate a common standard for professional competencies for use at all UK institutions. However, the implication that this needs to dominate the medical curriculum from year 1, at the expense of what is referred to as “liberal education” (with, one senses, a tone of disapproval) ought to be resisted.

The parallels with the US system are entirely inappropriate as national licensing exams there apply to students in their mid-20s who have previously benefited from a general undergraduate education of usually four years’ duration. It is a national scandal that many UK medical students enter their profession without the benefit of a conventional undergraduate education, as opposed to a narrow vocational training.

This is an issue not just because we think medical students need cramming with “scientific knowledge” before they engage in medical training. It's because we believe that a necessary feature of free societies is that those who enter public and professional life must first have developed the intellectual skills and habits of mind that will enable them to continue to contribute reflectively, fearlessly, and creatively to their society for the whole of their careers. The relentless march of quality controllers into the earliest stages of the undergraduate curriculum promises to rob what's left of UK medical education of its transformative value, and should be resisted at all costs. Roll on a UK wide, graduate entry medical system—we need a British Flexner.

William S James university lecturer in experimental pathology
Sir William Dunn School of Pathology, Oxford
OX1 3RF
william.james@path.ox.ac.uk

Competing interests: None declared.

Epirubicin seems to cause venous sclerosis

Editor—We agree with the findings of Bolton-Maggs and Flavin that epirubicin for breast cancer may cause considerable venous sclerosis.1 We became aware that after epirubicin had been introduced to standard adjuvant breast chemotherapy regimens, more and more women experienced problems with venous access.

We audited the treatment of 21 women receiving anthracycline based regimens, 19 of them as epirubicin 100 mg/m², 16 as adjuvant treatment. At the end of treatment only two patients reported no venous effects. The remaining 17 all reported painful, hard, and tethered veins, 12 of whom found the last effect unacceptable. Two patients withdrew from treatment partly because of the venous problems.

Careful assessment of peripheral veins is needed before any epirubicin based chemotherapy is started. Consideration should be given to the placement of a central venous or peripherally inserted catheter.

Elaine Lemman consultant nurse oncology
elaine.lemman@suh.sswest.nhs.uk

Janice M Middleton lecturer practitioner
Julia Lukon clinical nurse specialist
Southampton Cancer Centre, Southampton University Hospitals Trust, Southampton SO16 6YD

Competing interests: None declared.

Postcards from the edge

Homelessness poses extra challenge in reducing self harm

Editor—The idea of using postcards to reduce repetition of deliberate self harm is good,1 2 but it cannot be delivered to the entire population of those who self harm.

We looked at the incidence of deliberate overdose in our population of homeless patients from 1999 to 2003. There were 177 episodes in 116 patients, out of a population of 1617. This translated to an incidence of 7.2%, higher than that in the general population.

Taking an overdose, and other forms of self harm, are more common in homeless people, many of whom have multiple illness. Some can be followed up through support workers, while others remain chaotic and at risk. Postcards and text messages may help some to make contact, but others will remain uncontactable. At the very least, it helps when emergency departments or liaison psychiatry inform primary care providers—but this practice is patchy, to say the least.

Sally L Read general practitioner
NFA Health Centre, Leeds LS9 8AA
sallyread@btinternet.com

Competing interests: None declared.

Sports utility vehicles and older pedestrians

Achieving compatibility in motor vehicle crashes

Editor—The chief determinants for the degree of severity of injuries in motor vehicle collisions are vehicle size and weight. If all cars were designed to be equal in standard to the best car currently available in each class, then an estimated half of all fatal and disabling injuries could be avoided.

Sports utility vehicles (SUVs) differ from cars in three key areas: they have greater mass and stiffness and the geometry places bumpers above the frames of struck cars,
resulting in higher intrusion when striking smaller cars. Thus the safety designs that were effective 10 or 15 years ago are not adequate in today’s incompatible vehicle collisions. New technology needs to be developed and implemented. Although mass affects survival in crashes, good vehicle geometry and energy absorbing interfaces are important in developing a heavy vehicle that behaves in crashes like the average car. Safety standards for front-end construction which would make vehicles less hazardous to pedestrians and cyclists may be as important as standards that affect vehicle occupants. Political obstacles have made such standards difficult to implement.1,4

The high stiffness and aggressiveness of the front structures of heavy vehicles significantly exacerbates the injury risk to pedestrians, cyclists, and vehicle occupants. The front, side, and rear design of SUVs can be effectively modified to significantly reduce the harm of heavy vehicle crashes.4

Ediriweera B R Desapriya research associate edeapsi@cscdc.ca

Ian Pike assistant professor Department of Paediatrics—UBC, BC Injury Research and Prevention Unit, Centre for Community Child Health Research, 4480 Oak Street, L 408 Vancouver BC, Canada V6H 3V4

Competing interests: None declared.


Attitudes to SUVS and “slam door” rolling stock represent a paradox

Editor—Recently, I commented on the paradox in attitudes to safety in private and public transport. I suggested that obvious, cheaply implemented safety improvements to private motoring—the example of banning the use of mobile telephones was under discussion—are often greeted with a chorus of protest that they impinge on the “freedom” of the motorist. In contrast, public transport is expected to spend vast sums of money to improve safety, even if the improvement is likely to be marginal. I cited the example of the replacement of “slam door” rolling stock on Britain’s railways, which casualty records show will have a minimal effect. The case of sports utility vehicles (SUVs) represents another version of this paradox. It is self evidently obvious that pedestrians will be more damaged by a bigger heavier vehicle that is likely to be traveling faster than, say, a modest hatchback. Yet, one gets very little sense that the motoring community wants to eliminate SUVs in the way that slam door rolling stock is being eliminated on the railways.

Until the vociferous motoring lobby is curbed and the safety of private motoring is treated with the same sense of purpose as that expected of public transport, I see little optimism that the important message from Simms and O’Neill’s article will be acted on.

Tony H Reinhardt-Rutland reader in psychology University of Ulster ah.reinhardt-rutland@ulster.ac.uk

Competing interests: None declared.

SUV driving and adaptive behaviour

Editor—Simms and O’Neill point out the problems posed by a particular class of private motor vehicles (sports utility vehicles, SUVs) to one group of other road users. The danger posed by SUVs is simply a more extreme version of the problems posed by all motor vehicles to all other road users, not just elderly pedestrians.

The fundamental reason for a higher involvement of SUVs in pedestrian and other road user road traffic accidents is that SUV drivers feel better protected in their vehicle than in smaller private motor vehicles. SUVs are frequently advertised as being “safer” than smaller vehicles and give the impression of crashworthiness to potential buyers irrespective of any advertising campaigns.

The common sense knowledge that road users adapt to their perception of danger—generally referred to as “risk compensation” or “adaptive behaviour”—is well documented. Thus, the danger from SUVs comes at least partly from a tendency by the “road safety establishment” (including the medical establishment) to protect those dangerous to others from the consequences of their actions rather than reducing danger at source by means such as automatic speed control, black box technology to identify cause in road crashes, higher levels of law enforcement, and deterrent sentencing, etc. Most importantly, a crucial need exists to reduce motor vehicle traffic and the fuel burnt by motor vehicles: in this case increasing the cost of fuel would reduce the attractiveness of SUVs to consumers.

Competing interests: None declared.

Letters

Not all SUVS are the same

Editor—The editorial by Simms and O’Neill on sports utility vehicles (SUVs) and older pedestrians contributes some interesting points to a highly emotive subject. However, I wish to dispel a myth—not all SUVs are poorly designed for pedestrian safety, and not all non-SUV cars offer better protection than SUVs. For example, the European New Car Assessment Programme (Euro NCAP) reports that the Honda CR-V scored three stars out of a possible four in 2002, one of the highest pedestrian safety scores recorded. In contrast, the Audi TT roadster scored no stars in 2003,1 and the Renault Clio one star in 2005.

In this world of evidence based practice, the perils of generalisation must be avoided—for example, “The proliferation of sport utility vehicles represents a backwards step in safer vehicle design”—and statements be based on fact. Undoubtedly, car design is a factor in pedestrian safety in an impact, but this is not correlated to one particular class of vehicle.

John S Watts locum consultant psychiatrist Child and Adolescent Mental Health Service, Lernermouth Clinic, Ashford, Kent TN24 9QE johns.watts@ekht.nhs.uk

Competing interests: JSW drives a Honda CR-V.

SUV use: a factor in pedestrian safety in an impact, but other road users have the same interest.

O’Neill on sports utility vehicles (SUVs) and concludes that consumers who are interested in potential risk to pedestrians through notices on these vehicles. This solution fails to consider the psychology of SUV drivers, most of whom do not need four wheel drive off-road capability. There are few hill farms in Chelsea. Ownership of such a vehicle represents the conspicuous display of wealth and a deliberate attempt to look down on, both physically and metaphorically, poorer, less important people such as public transport users and pedestrians.

In the United States to drive an SUV is seen as a fundamental freedom like the other lethal freedom, gun ownership. Some have tried to curb use by invoking other belief systems: WWJD “What would Jesus drive?” The authors cite the success of antitobacco campaigns, but there is a difference: smoking mostly damages the smoker and SUV driving damages others. SUV ownership will only reduce if the cost of the vehicle truly reflects the cost to the environment through pollution and pedestrians through impact. While consumers have the “I’ll give up my SUV when you prise it from my cold dead hands” mentality, health professionals will have to carry on pressing dead pedestrians from the front of SUVs.

Robert A Davis policy adviser Road Danger Information Forum, London NW1 2AS rldavis499@aol.com

Competing interests: None declared.

Solution must consider psychology of SUV

Editor—Simms and O’Neill warn of increasing death and injury from sports utility vehicles (SUVs) and conclude that consumers should be warned of potential risk to pedestrians through notices on these vehicles. This solution fails to consider the psychology of SUV drivers, most of whom do not need four wheel drive off-road capability. There are few hill farms in Chelsea. Ownership of such a vehicle represents the conspicuous display of wealth and a deliberate attempt to look down on, both physically and metaphorically, poorer, less important people such as public transport users and pedestrians.

In the United States to drive an SUV is seen as a fundamental freedom like the other lethal freedom, gun ownership. Some have tried to curb use by invoking other belief systems: WWJD “What would Jesus drive?” The authors cite the success of antitobacco campaigns, but there is a difference: smoking mostly damages the smoker and SUV driving damages others. SUV ownership will only reduce if the cost of the vehicle truly reflects the cost to the environment through pollution and pedestrians through impact. While consumers have the “I’ll give up my SUV when you prise it from my cold dead hands” mentality, health professionals will have to carry on pressing dead pedestrians from the front of SUVs.

David R J Jarrett consultant geriatrician Queen Alexandra Hospital, Portsmouth, Hampshire PO6 0JW

Competing interests: None declared.


