Letters

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 (employer, employee contributions, local authority taxation), private and voluntary insurance, and user charges—are all, in that order, increasingly regressive and inefficient. Above all they introduce the potential for disaggregating and fragmenting the risk pool, allowing funders to pick and choose who gets coverage according to ability to pay and profitability. Increasingly this evidence is obscured by the mantra that the NHS is "unsustainable" and "unaffordable."

Just as the method of funding matters, so too does delivery. All universal services have the goal of equity and universal coverage and have to be organised in such a way as to incorporate the principle of equal distribution in terms of need, not ability to pay; and, in the case of health services, to separate clinical decisions from issues of funding. The principle of not allowing fragmentation of coverage and mechanisms also extends to populations, treatments, services and training, public health support, and information.

Hitherto, health care has been organised and funded according to the needs of geographical populations for services, giving responsibility to administrative tiers responsible for meeting the needs of all patients and populations within their areas and ensuring that services are in place to provide them. Redistribution is the key to ameliorating inequalities and has to be designed both into funding and into delivery. Thus the flow of resources has been linked to needs and services, through the Resource Allocation Working Party and prospective budget setting. Politics often disrupted this process, but this was due to failings in democracy and accountability, rather than to failure in organisational design.

The abandonment of these principles is constantly justified by two claims or theses: that it doesn't matter who delivers care so long as it remains publicly funded; and that private sector delivery introduces choice, contestability, and diversity, leading to greater efficiency. In neither case is valid evidence presented.

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 allay 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.

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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.[1] 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?

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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[1]) that those "neutrals" unencumbered 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.

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.

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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 Atun and McKee in their editorial[1]), shortage of hospital capacity,[2] 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 prudency and transparency; proof of principle from pilot studies; and a clearly defined audit process to assess the clinical and economic impact of reform on healthcare 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.

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1 Atun RA, McKee M. Is the private finance initiative dead? *BMJ* 2005;331:792-3. (8 October.)
2 Gaffney D, Pollock AM, Price D, Shaoul J. The private finance initiative: NHS capital expenditure and the private finance initiative—expansion or contraction? *BMJ* 1999;319:48-51.

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.[1]

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 teamworking, carrying personal financial risk but also the possibility of reward for success, is not new or unique to British general practice. It lies behind the success of the Kaiser Permanente health maintainance 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?


Doctors get 20% pay rise just for doing their jobs

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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.[1]

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.

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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 is overlooked, which with that volume is a nigh 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.

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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 sciatica 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 government can't call the tune.

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

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.[2]

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1 Wass V. Ensuring medical students are "fit for purpose." *BMJ* 2005;331:791-2. (8 October.)
2 Flexner A. *Medical education in the United States and Canada.* New York, NY: Carnegie Foundation for the Advancement of Teaching, 1910.

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/m^2, 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 lasting 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.

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1 Bolton-Maggs P, Flavin A. Epirubicin for breast cancer may cause considerable venous sclerosis *BMJ* 2005;331:816. (8 October.)

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.

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1 Hatcher S, Owens D. Do get in touch. *BMJ* 2005;331:788-9. (8 October.)
2 Carter GL, Clover K, Whyte IM, Dawson AH, D'Este C. Postcards from the EDge project: randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. *BMJ* 2005;331:805. (8 October.)

GPs have role in reducing repetition of self harm

Editor—Interested general practitioners may be the key to providing continuity of care to patients who self harm.[1 2]

I am a general practitioner working in an inner city practice that serves many university students. The hospital emergency department sends a notification of attendance to the general practitioner of all patients who visit hospital having deliberately harmed themselves. Our general practice automatically sends letters inviting these patients to make a double appointment to see one of us so that we can provide local follow up and support. We asked the emergency department to be more precise when describing lacerations—accidental or deliberate—so we could target the correct group. About half the patients respond. About half the patients are already known to us as having mental health problems.

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1 Hatcher S, Owens D. Do get in touch. *BMJ* 2005;331:788-9. (8 October.)
2 Carter GL, Clover K, Whyte IM, Dawson AH, D'Este C. Postcards from the EDge project: randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. *BMJ* 2005;331:805. (8 October.)

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.[1]

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.[2] 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.[3]

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.[2 3 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.[3]

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1 World Health Organization. *World report on road traffic injury prevention.* Geneva: WHO, 2004.
2 Rowe SA, Sochor MS, Staples KS, Wahl WL, Wang SC. Pelvic ring fractures: implications of vehicle design, crash type, and occupant characteristics. *Surgery* 2004;136:842-7.
3 Desapriya EB, Chipman M, Joshi P, Pike I. The risk of injury and vehicle damage in vehicle mismatched crashes. *Injury Control Safety Promotion* 2005;12 :191-2.
4 Simms E, O'Neill D. Sports utility vehicles and older pedestrians. *BMJ* 2005;331:787-8. (8 October.)

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 thoughts to a highly emotive subject.[1] 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.[2] In contrast, the Audi TT roadster scored no stars in 2003,[3] and the Renault Clio one star in 2005.[4]

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 confined to one particular class of vehicle.

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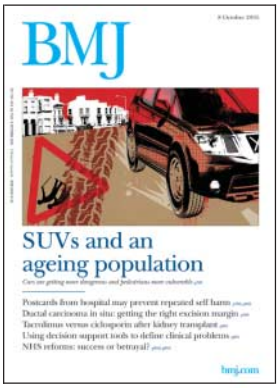
1 Simms C, O'Neill D. Sports utility vehicles and older pedestrians. *BMJ* 2005;331:787-8. (8 October.)
2 Euro NCAP website. www.euroncap.com/content/safety_ratings/ratings.php?id1 = 10 (accessed 10 Oct 2005).
3 Euro NCAP website. www.euroncap.com/content/safety_ratings/ratings.php?id1 = 8 (accessed 10 Oct 2005).
4 Euro NCAP website. www.euroncap.com/content/safety_ratings/ratings.php?id1 = 1 (accessed 10 Oct 2005).

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.[1] 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 expression of this paradox.[2] It is self evidently obvious that pedestrians will be more damaged by a bigger heavier vehicle that is likely to be travelling 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'Neil's article will be acted on.

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1 Reinhardt-Rutland TH. *Psychologist* 2005;18:199.
2 Simms C, O'Neill D. Sports utility vehicles and older pedestrians. *BMJ* 2005;331;787-788. (8 October.)

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.[1] 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 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"[2] or "adaptive behaviour"—is well documented.[3] 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 measures 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.

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1 Simms C, O'Neill D. Sports utility vehicles and older pedestrians. *BMJ* 2005;331;787-8.
2 Adams JGU. *Risk*. London: UCL Publications, 1995.
3 Davis R. *Death on the Streets: cars and the mythology of road safety*. Hawes: Leading Edge Press, 1992.

Solution must consider psychology of SUV use

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.[1] 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 dead fingers" mentality, health professionals will have to carry on prising dead pedestrians from the front of SUVs.

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1 Simms C, O'Neill D. Sports utility vehicles and older pedestrians. *BMJ* 2005;331:787-8. (8 October.)