The challenge of elderly care in Glasgow's East End, p 981

A Dutch window into the development of a two tier healthcare system

PERSONAL VIEW **Joe V Guadagno, Chris H Polman**

May we fire a warning shot across the bows—to use a maritime analogy, as is common in the Netherlands—with regard to the renegotiation of contracts in the next phase of the development of independent sector treatment centres? These centres were originally designed (partly) to introduce "apparent" healthy competition into the "inefficient" NHS in England. We say "apparent," as we would like to emphasise that, contrary to what's being touted, when it comes to competition it is certainly not a level playing field, to use a more British expression (as they are all level here in the Netherlands). This was brought home to us in a vivid and extreme example while reviewing a patient at the VU Medical Centre in Amsterdam, where private healthcare providers have been in competition for a number of years.

A man with rather benign but definite multiple sclerosis was re-referred to the VU's multiple sclerosis centre at the request of a private orthopaedic clinic. He had been due to have a standard cartilage repair arthoscopically, but this was cancelled by the clinic when its clinicians realised (after anaesthetic review) that he had a diagnosis of multiple sclerosis. He was told that he couldn't have his operation at the clinic because it had no intensive treatment facility, which he might need, given his comorbidity. This man had no neurological deficits and no other comorbidities.

It is increasingly common in the Netherlands for private healthcare providers to select their patients. In 2006 the Dutch healthcare system changed from state managed sickness funds to an obligatory healthcare insurance system—that is, Dutch citizens legally had to purchase their health care from profit making private health insurers. The insurance companies are legally obliged to accept all applications regardless of the client's current, or risk of, chronic ill health (as the government operates a risk equalisation scheme, which pays extra in compensation for patients with chronic ill health). However, healthcare providers are not obliged to take on these high risk patients; and, with the incessant driving force of profit, providers are enforcing rigorous efficiency.

This entails carrying out as many procedures as possible in a given time. Providers perceive any delay or anything that might lead to delay—such as a longer time to recover from anaesthesia, a higher risk of infection or seizures, or difficulties in becoming ambulatory for whatever reason—as a threat to their cost effective model of health care. Thus any hint of a potential problem is "cut off at the pass"; for example, a provider might simply not accept a patient, using excuses such as, "See your neurologist for a referral to a state hospital with an intensive treatment unit in case of complications."

Unsurprisingly, such providers' clinical outcomes and turnaround times can be excellent; they are likely to be heralded triumphantly for all to see how good health care can be in the private sector. Meanwhile, poor old state funded hospitals, with no ability (or desire) to refuse patients, have far higher delays and complication rates, and the blame is attributed (usually for political purposes) to unclean hospitals and poor nursing and medical care.

The underlying, insidious philosophy of increasingly rigorous selection of patients becomes, in time, all pervasive in healthcare models involving for-profit independent sector providers. Its effects are subtle, and at first it tends to go unacknowledged by patients and healthcare workers alike. The trouble is that the health care of a population is a big financial cake, the private sector able to cherrypick the best bits for optimal profit. Therefore, the cost effectiveness of independent sector treatment centres needs rigorous ongoing scrutiny, especially in a tax funded healthcare system.

In England the independent sector treatment centre programme has so far been generous to the independent sector (www.civitas.org.uk/wordpress/2009/08/13/the-value-for-money-of-istcs/; http://alternativeprimarycare.wordpress.com/2009/08/05/istcs-are-they-cost-effective/). And although the NHS has been moving to payment by results, the independent sector has usually been awarded five year block grants on predefined levels of activity made on the basis of primary care trusts' predictions. The initial contracts guaranteed payments for the volumes of activity stated, but referral rates were low in the early years, so the independent sector centres were paid even though many didn't provide the contracted volumes. Amazingly the tariffs were even more generous, being the equivalent to the NHS payments plus 15%.

JAN VERMEER "GIRL WITH A WATER PITCHER"

The Netherlands' experience suggests "cream skimming" of patients is inevitable

We believe it necessary to highlight the additional and—from the Dutch experience—inevitable practice of patient selection or "cream skimming," the avoidance of complex cases to ensure the quick processing of patients to yield maximum profit. We believe that this factor needs to be included in the contracts and tariff setting currently under discussion for the new phase 2 development of the independent sector treatment centre programme. It also has to be factored into the overall cost effectiveness of these centres to the NHS—a task urgently needed before their role is increased.

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REVIEW OF THE WEEK

China's son preference—consigned to history?

An emotive account of the preference for male babies in China gives a misleading impression, believes **Thérèse Hesketh** on the basis of her experience as a paediatrician there

Message from an Unknown Chinese Mother: Stories of Loss and Love

Xue Xinran

Chatto and Windus, £16.99, pp 224

ISBN 978-0701184025

Rating: ★★ ☆☆

For thousands of years a preference for sons has been prevalent in an arc of countries from east Asia through south Asia to the Middle East and north Africa. Sons are preferred because they have a higher wage earning capacity, especially in agrarian economies; they continue the family line; and they are generally recipients of inheritance. In some countries girls are an economic burden, because of the dowry system, and after marriage they typically become members of the husband's family, ceasing to have responsibility for parents in old age. Over the centuries the preference for sons has led to female infanticide and the abandonment and neglect of girls.

This book provides an illuminating insight into the lives of a few of those women who have been forced to give up their daughters as a result of this sociocultural pressure in China. Xue Xinran was a journalist and local radio presenter in China between 1989 and 1997 but has now settled in England, where she runs a charity to support adopted Chinese children. According to its foreword the book is intended primarily for these Chinese adopted girls, who seek explanations for why their mothers abandoned them. The underlying reason is, of course, sex preference, complicated since 1979 by the one child policy. But other problems are unrelated to the policy: women who are unmarried and unsupported, and sheer economic necessity.

The stories shine a light on the human tragedy behind the abandonment of daughters. The book describes interviews that Xinran conducted with a number of women who tell moving stories about being forced to give up their daughters. There is the story of the isolated and shunned unmarried mother who could not afford to keep her daughter; the woman who gave away two daughters for adoption by foreigners and still worried years later that foreigners wouldn't know quite how to care for them; the woman who tried to commit suicide because she had smothered her own baby daughters; the peasant rejected by her own family for failing to produce sons; and the women who already had daughters and who, to have a son, left their home towns to escape family planning authorities. The stories are told in an unapologetically emotive tone, and Xinran seems at times to be shocked, which is surprising to me, given that in 1980s China these sorts of stories were certainly in the public domain.

The focus is on mothers and daughters, giving the impression that the abandonment of boys doesn't exist, but of course many boys (and girls) with disabilities and deformities are abandoned too. Although figures are hard to obtain, it is estimated that more than a quarter of children in orphanages are boys and that a third have some form of disability. Fathers are also barely mentioned, as if mothers have a monopoly on emotion and suffering. Xinran pulls no punches on this subject: "Men will never understand the emotional bond between a woman and her baby . . . Every injury to the child is ten thousand times more painful to the mother than cutting flesh from her own body."

The focus is on mothers and daughters, giving the impression that the abandonment of boys doesn't exist, but of course many boys (and girls) with disabilities and deformities are abandoned too

The impression given is that these stories are typical, but this is misleading. I worked in China as a paediatrician (mainly in neonatology, so at the sharp end) in cities and in rural areas during much of the period that most of these stories seem to refer to, the mid to late 1980s. The idea that in rural China the birth of a girl is a disaster, especially when that girl is the first child, is erroneous. In fact, in much of rural eastern and central China, where most of the population live, couples want their first child to be a girl, because under the one child policy they are then automatically allowed a second child.

It also needs to be emphasised that these stories relate to a period when the policy was more strictly enforced. Many areas of life in China have seen huge changes in the past 20 years, including in reproductive choice. Sex selection can now be made prenatally with very easily available (though theoretically illegal) sex selective abortion. This has created a high sex ratio of around 120 male births to 100 female. This has been labelled "gendercide" and is clearly undesirable on ethical grounds, of course, but also because of concerns about the huge number of poor, rural men now unable to find a spouse. But this high sex ratio is having positive effects for women. They are more valued, and their status across a range of measures has risen. For example, there are now almost equal numbers of men and women completing university education. The government's "Care for Girls" campaign is reaping benefits, with sex ratios falling in the areas where the campaign has been active. Research shows that increasing numbers of couples, 20% in some areas, would prefer a girl, and nearly a half have no sex preference. With such rapid change it is to be hoped that the tragic stories that fill this book will soon be a true rarity and largely of historical interest.

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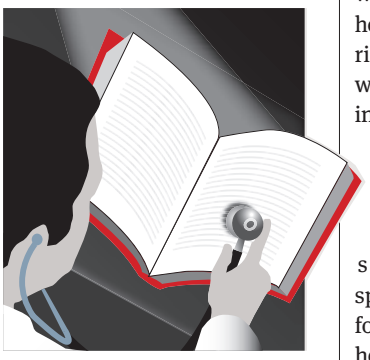
News: Chinese would resist having larger families if one child policy was relaxed (*BMJ* 2010;340:c1212).

The poisoner's handbook?

BETWEEN THE LINES
Theodore Dalrymple



One cannot help wondering whether Dr Bodkin Adams had read *Malice Aforethought* before embarking on his career in Eastbourne

The only objective of a writer, said the critic Cyril Connolly, is to write a masterpiece. This is nonsense, of course, unless it is made true by definition: that no writer who does not aim at one is really a writer. Nevertheless it is undeniable that most writers would prefer to have written a masterpiece than not to have written one, in which case Anthony Berkeley Cox (1893-1971) ought to have died fulfilled—though almost certainly he did not, for he wrote no fiction for the last 32 years of his life.

His masterpiece, published in 1931 under the pseudonym Francis Iles, was *Malice Aforethought*. The hero of this book, or perhaps I should say protagonist, is a doctor: Dr Edmund Alfred Bickleigh. The book begins: "It was not until several weeks after he had decided to murder his wife that Dr Bickleigh took any steps in the matter."

Dr Bickleigh, a general practitioner in the genteel fictional Devonshire village of Wyvern's Cross, is eventually acquitted of the one murder he did commit but hanged for one he did not. Justice of a kind, therefore, is done.

No Freudian, as far as I am aware, has as yet made much of the fact that Cox's father, like the father of so many writers, was a doctor and that the execution of Dr Bickleigh might therefore be considered the symbolic fulfilment of an oedipal wish. Moreover, Dr Bickleigh's small size and physical insignificance might likewise be deemed the author's oedipal revenge upon his father.

In fact Dr Bickleigh strongly resembles Dr Crippen, though his methods look forward to those employed by Dr John Bodkin Adams (see Between the Lines, *BMJ* 2007;335:351).

As a man who recognises his "wormhood," Dr Bickleigh tries to compensate by philandering, at which he is surprisingly successful. His method of disposing of Julia, his snobbish and shrewish wife, in the vain hope of marrying the rich young woman who is his current inamorata is first to give her headaches by means of a proprietary drug called Farralite, surreptitiously sprinkling it on her food, then to addict her to the morphine that he gives her to relieve those headaches, and finally to kill her with an overdose. One cannot help wondering whether Dr Bodkin Adams had read *Malice Aforethought* before embarking on his career in Eastbourne.

Mrs Bickleigh is one of the most splendidly awful wives in literature. She considers herself socially superior to her husband: "Before her marriage Mrs Bickleigh had been a Crewstanton. She was, in everything but name, a Crewstanton still . . . During their short engagement she had informed her fiancé not once, but several times, that her grandmother would no more have contemplated sitting down to a meal with her doctor than with her butler."

Dr Bickleigh, hen pecked by his wife, is always falling in love with a different young woman: "He did not doubt that she was the young woman in the world whom he ought to have married. The fact that he had been looking for this one woman so long made his discovery all the more poignant; the fact that he had been certain so often before of having found her elsewhere did not affect the matter in the least."

Malice Aforethought is as much a brilliant comedy of manners as a crime novel and as much a depiction of self deception as a comedy of manners. It therefore repays close study: for men were deceivers ever, both of themselves and others.

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MEDICAL CLASSICS

Survival of the Unfittest: A Study of Geriatric Patients in Glasgow

By Bernard Isaacs, Maureen Livingstone, and Yvonne Neville **Published in 1972**

Bernard Isaacs had the good fortune to enter the emerging specialty of geriatric medicine in the 1950s at Glasgow's Stobhill Hospital, where Professor Ferguson Anderson and his colleagues understood the challenge of rehabilitating the elderly patients with chronic diseases who had been admitted to their wards. In 1975 Isaacs left Glasgow when he was appointed to the chair of geriatric medicine at Birmingham University. In his 15 years there Isaacs created a teaching programme for medical students and developed specialist training for doctors entering geriatric medicine. He set up a clinic to look at falls in old age, and he recognised the importance of managing urinary incontinence. He was instrumental in creating Birmingham University's Centre for Applied Gerontology, and after he retired he published *The Challenge of Geriatric Medicine* in 1992.

However, it will be for *Survival of the Unfittest* that Isaacs will be best remembered. Carefully researched, based on extensive case studies, and written with the social workers Maureen Livingstone and Yvonne Neville, this book covered the problems relating to the elderly infirm in deprived areas of Glasgow's East End. The conditions it described related to real people, and the authors sought real solutions with compassion. They related an incident of an elderly woman "lying on the floor of her house throughout the wintry night," which they believed "symbolises a social evil." How has this, Isaacs asked, and the many other cases of deprivation in elderly people, "been allowed to come about in the midst of a welfare state, and what can we do to ensure that such things do not continue to happen?"

Pub drinkers, Glasgow, 1968

JURGEN SCHADEBERG/GETTY IMAGES

Survival of the Unfittest describes the evolution of geriatric services in the East End. A department of geriatric medicine was established at Glasgow's Royal Infirmary in 1964, but Isaacs ruefully noted that most patients transferred from general medical and surgical wards failed to improve after full investigation and treatment. This confirmed his belief that geriatrics was a specialty in itself, that its patients presented problems of "great complexity," and that "special knowledge, insight, and skill are required of a doctor who devotes himself to their care."

Isaacs and his colleagues believed that many unmet needs prevented their geriatric patients from reaching their full recovery potential: lack of basic care, the patient's refusal to accept help, and neglect by the family and wider society. They also acknowledged that neglect may occur despite the best efforts of care agencies or family members. Written 40 years ago, *Survival of the Unfittest* remains a testimony to a far sighted physician and his colleagues who painstakingly placed care of elderly people at the forefront of their endeavours.

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The X factor

FROM THE FRONTLINE
Des Spence

I struggled to clip my son into his car seat. "Dad, you know that you can get cash for gold?" "Really!" I made yet another mental note to stop him watching television with his older brothers. But on a more educational note we sat with all the children to watch the party leaders' debate. "Now, this is important," I said. But they looked less than convinced. Then came the questions: "Why are they all men?" "Because only men are stupid enough to want to be prime minister," my wife explained helpfully. "They all sound the same!" "That's because all their policies are exactly the same and generally they attended the same schools and universities," I added. "Is SuBo on as well, Dad?" "Right, sod this, who wants to watch *Outnumbered*?" Cheers all round. Does the election actually matter?

My neighbour got hit by a brick demonstrating against the National Front in the 1970s. Then, politics were passionate and mattered to people. I was a member of the Labour party but left a few years ago, tiring of being told what to think and bored with the regurgitated, crude dogma of a bygone era on class, gender, and the rest. In the noughties we were a nation tediously chattering only of houses, holidays, schools, and celebrity, a nation devoid of any real sense of purpose. Not suffering from too little but from too much, we had become political couch potatoes who couldn't be bothered changing the political channel. Now, in the recession, many people have been left sitting on the floor—politics and values again seem to matter.

But the old foundries of conflict are derelict. The NHS is safe. Even the most buccaneering council house capitalist is aware of the health wasteland of the United States, where the market system has seen the pursuit of wealth through health and has resulted in polarised, thoughtless, and bad medicine. So, rightly and logically all parties support socialised medical care. Also, 25% of current public spending is borrowed, therefore even the most public school Marxist can see that taxes will need to rise and spending to be cut. Necessity is the mother of invention; and we will get a better, more efficient public sector and NHS in the long run.

Thus change is coming irrespective of the hue of the rosette. With a hung parliament a strong possibility, perhaps the time has come to work together, compromise being a source of human civility. Consensus may also help to deliver much needed change. So it's time to vote for our favourite housemate, *Big Brother* style. Political doctors will froth over their cappuccinos, many will stay up all night, blurry eyed, for the result. Good luck to all.

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Lancets and libel

PAST CARING
Wendy Moore

COLIN CRISFORD

Whether exposing quackery in complementary medicine or challenging malpractice in orthodox medicine, journalists have always needed nerves of steel—though deep pockets are sometimes useful too. But, in navigating Britain's repressive libel laws, modern medical hacks can always turn for inspiration to Thomas Wakley.

Trained in surgery at St Thomas's and Guy's Hospitals in London, Wakley (1795-1862) was disillusioned by the nepotism and bungling that he saw. In 1823 he founded the *Lancet* in a mission to end the "mystery of concealment" in medicine. Noting that a lancet was both "an arched window to let in light" and "a sharp surgical instrument to cut out the dross," he said, "I intend to use it in both senses."

True to his word for the next 34 years, Wakley deployed his *Lancet* both to shine a light on abuse and to lance the boil of corruption in every corner of health care. From the first edition, which revealed the ineffectual components of quack remedies, such as Daffy's Elixir, Wakley had no time for charlatans. He denounced homoeopaths as an "audacious set of quacks" and their followers as "noodles and knaves."

But he reserved his sharpest criticism for the medical establishment. Recruiting a team of medical students as undercover reporters, Wakley filled his columns with lampoons of medical bigwigs and reports of clinical mishaps, including blow by blow accounts of botched operations, under the title "Hole and corner surgery." Refusing to kowtow to authority he dubbed the Royal College of Surgeons the "bats' cavern" and nicknamed the top surgeons at St Thomas's the "three ninny hammers."

Inevitably the writs came thick and fast. In the first 10 years Wakley fought 10 lawsuits, including six libel cases. In the first case, in 1824, the Barts surgeon John Abernethy won an injunction prohibiting Wakley from publishing his weekly lectures, which students could read for the sixpence cover price of the *Lancet* instead of the usual £5 fee. Wakley simply ignored the injunction, and Abernethy backed down. Another surgeon, Frederick Tyrell, was less easy to appease. Accused of plagiarism by Wakley, he sued for libel and won his case—with a derisory £50 award.

But Wakley's most famous libel case came in 1828, when he published details of a hopelessly inept and ultimately fatal operation to remove a bladder stone by the Guy's surgeon Bransby Cooper under the headline, "The operation for lithotomy by Mr Bransby Cooper which lasted nearly one hour!" Conducting his own defence to a crowded courtroom, Wakley lost his case but won a moral victory: supporters paid his £100 fine.

A tireless crusader for press freedom and medical reform who also campaigned against food adulteration and naval flogging, Wakley serves as an example to encourage journalists, writers, and bloggers worldwide.

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