LIFE AND DEATH Iona Heath

The blind leading the blind

The government's plan for reforming London's health care will be to the detriment of primary care

Ara Darzi is an eminent and respected professor of surgery at Imperial College London, and he is now a junior health minister in Gordon Brown's government. It is clear from the academic literature that he knows an immense amount about surgery in general and laparoscopic surgery in particular. However, tragically it is equally clear, from reading his vision for transforming health care in London, *Framework for Action*, that he has learnt nothing about general practice and primary care. Given the robust evidence that a strong basis in primary care improves the effectiveness and efficiency of healthcare systems, and when primary care is responsible for 82% of contacts with patients in the NHS, it must be asked who thought it could possibly be a good idea to ask a tertiary care specialist to redesign the provision of primary care.

The key part of Professor Darzi's plan is a network of "polyclinics," each serving a population of around 50 000 people and within which GPs and specialists are to work side by side. This innovation is supposed to improve the integration of and accessibility to the health service in London, but this hope is vainly based on a profound misunderstanding of the utility of differentiating medical generalists from specialists. Generalists working at the point of first contact develop pragmatic skills that enable them to deal with the uncertainty that is inevitable when the prevalence of serious disease is low and to manage safely the vast majority of problems presented to them. Only 5% of GPs' consultations result in referral to specialist care; and this interface between primary generalist care and secondary specialist care marks a step change in the prevalence of serious pathology, which enables specialists to use costly investigations and skills in a focused and effective way.

The *BMJ* has had a perceptive rapid response to its initial coverage of the Darzi report, from Vasily Vlassov of the Moscow Medical Academy (www.bmj.com/cgi/eletters/335/7610/61-a). He points out that in Russia they know a

thing or two about what happens when generalists and specialists are brought together in polyclinics: generalist skills are damaged because care is fragmented and continuity is disrupted; specialist skills are eroded by work with populations where prevalence is low and where the predictive values of symptoms, signs, and investigations diminish proportionately. Given the UK's recent record of introducing sweeping change without piloting and evaluation, it becomes even more essential to pay heed to the experience of others.

Framework for Action uses the simplistic vignettes that seem to have become compulsory in NHS policy documents, showing the imperfections of the present alongside the best of all possible worlds, which must inevitably result from the careful implementation of Professor Darzi's vision. The problem from the perspective of everyday general practice is that each patient in these stories has only one problem. Kishore has diabetes; Andrew has pneumonia. Unfortunately, the real test of a health service arises when one of these patients is also an alcoholic or has schizophrenia. The report makes no mention of the complex situations that are a daily occurrence in London general practice, involving patients who, while theoretically able to benefit from the provision of multiple services on a single site, are much more often frightened and intimidated and so find it easier to engage with local services on a more domestic scale and at a distance from large institutions.

The framework describes two possible locations for polyclinics, which are to be "more accessible and less medicalised than hospitals." One location is "freestanding . . . in the community"; the other is "co-located with every hospital" as the "front door" to accident and emergency (A&E). Perhaps only a tertiary care consultant is able to see a polyclinic located at the front door of A&E as more accessible and less medicalised than the hospital itself. The scarcity and expense of vacant land in London makes the freestanding

“Who thought it could possibly be a good idea to ask a tertiary care specialist to redesign the provision of primary care?”

option less likely and the prospect of primary care controlled by hospital foundation trusts proportionately more so. In whose interests will this work?

The document has an admirable ambition of addressing health inequalities, and it explicitly acknowledges that the most deprived areas with the greatest health needs require better access to high quality health care. But, in the context of a plan that puts an emphasis on productivity, the problem remains that patients with the greatest needs will always need more time. Those on the losing end of health inequalities are much more likely to have multiple physical, mental, and social problems, each of which compounds the others. The report says that "mental health service users should be put in control," but the emptiness of this rhetoric is underlined by the admission that advice on mental health services was taken from a group made up of 10 chief executives, one management consultant, one "development consultant," and one race equality director. No clinicians of any sort were included, let alone any of the patients who are to be put "in control."

Professor Darzi wants a "world-class healthcare system" for a "world-class city." Unhappily, the city itself generates enormous socioeconomic inequalities, with obscene differentials in opportunity and life experience. No health service, however perfect, can prevent these differentials being reflected in the health of those who live them. Yet health inequalities are being used as the justification for reorganising health care and disrupting and further fragmenting general practice and primary care. Londoners have a much better chance of a decent health service through incremental improvements that build on those excellent services that already exist, rather than through the visions of a professor and a government neither of whom is able to see, let alone develop, the strengths and potential of generalist medical care.

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MEDICINE AND THE MEDIA

Cosmetic surgery gets under Dutch skin

A documentary has seen thousands rally against cosmetic surgery for under-18s, writes **Tony Sheldon**

Television programmes in the United States and Italy have been criticised in the past for trivialising cosmetic surgery and misrepresenting the realities of taking such a step (*BMJ* 2003;327:295 and *BMJ* 2004;328:520). Now a frank Dutch documentary, in which the film-maker is shown consulting a surgeon on whether to have vaginal surgery, has ignited a campaign in the Netherlands to ban non-essential cosmetic surgery for under-18s.

In *Beperkt Houdbaar* (Over the Hill), broadcast in the Netherlands this month for a second time, we see Dutch film maker Sunny Bergman visiting a cosmetic surgeon. "You could really, really stand for a laser reduction labioplasty," the surgeon enthusiastically declares, eventually concluding his critique of Ms Bergman's vagina with: "You need the full works, my dear."

The price starts with "laservaginal rejuvenation for enhancement of sexual gratification, that's \$8000." The surgeon says, "With that you will have that *Playboy* look." Bergman asks: "But do you think I am beautiful as I am?" The surgeon replies: "It's whatever you feel. It's not for others to judge."

Why women feel a need to change their bodies to feel good is tackled head on in Bergman's provocative documentary. It has sparked a fierce debate on the negative influence of the media and cosmetics industry on women's self image.

It stresses the huge impact of an idealised cultural norm of youth and beauty served up by television, magazines and the internet, such that by the time every girl reaches 17 she is likely to have seen an estimated 250 000 beauty related images. Every year in the Netherlands 1 000 young women seek cosmetic vaginal surgery—but why?

One factor blamed is today's manipulation, or "Photoshopping," of images, almost universal in Dutch glossy and youth magazines. To illustrate this Bergman has her image manipulated with Photoshop—a line brushed out, the upper lips balanced, and eyebrows straightened. You see now the "sexy and glamorous" Photoshop image next to the "ugly sister" of reality.

Since *Beperkt Houdbaar* was first broadcast in March more than 7000 people, including many Dutch MPs, have signed a manifesto against "the

Sunny Bergman: before and after Photoshop

sexualisation of society" where feminine images are defined exclusively by unrealistic ideals of beauty. The Society of Sexuology, comprising professionals working in health and education, has backed the manifesto, in particular its proposal to ban non-essential cosmetic surgery for under-18s. Legal challenges are also being considered against the cosmetics industry and, this month, several magazines are to state if they use manipulated photos or whether they are "Photoshop free."

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RESPONSE Neil Hunt Alzheimer's Society replies to Iain Chalmers

The question of who should have access to Alzheimer's drugs has sparked a heated debate on the way the National Institute for Health and Clinical Excellence (NICE) decides whether treatments are cost effective. Sir Iain Chalmers attacked the Alzheimer's Society (*BMJ* 2007;335:400) for our legal challenge against the NICE guidance on Alzheimer's drugs. He alleges that we formed an alliance with pharmaceutical companies to the detriment of people affected by dementia and challenges us to be transparent about our commercial relationships.

I wonder why supposedly informed commentators cannot conceive that our actions might be genuinely informed by the views of our members. Earlier this year, I met with NICE chairman Sir Michael Rawlins to challenge his apparent view that commercial interests were driving the campaigning agenda of the society. Now another associate of NICE repeats these tired allegations. We are an independent organisation. Funding is a massive challenge for us, of course. But it is a fundamental

principle that we speak and act on the basis of our own knowledge—however inconvenient that may be for those who would prefer us to step into line.

We went to court independently and funded our case through public donations. We were there to represent people with dementia and their carers. It was the logical extension of a campaign that began when NICE published its draft guidance, in March 2005, and proposed that no one with Alzheimer's should have access to drugs on the NHS. It should not be forgotten that our efforts changed that proposal so that today those in the moderate stages of the disease have access to treatment.

On Sir Iain's specific challenge to be transparent, we already publish details of donations from pharmaceutical companies on our website (0.1% of our income in the last financial year), along with our policy on working with them (www.alzheimers.org.uk/About_our_work/About_the_Society/pharma.htm).

He also suggests that we should publicly call for all trial data to be

published. We have done this on a number of occasions and will continue to do so.

NICE has a crucial job to do in recommending how the NHS should direct finite resource. However, I cannot agree that we should not have responded to important guidance that breached both the Disability Discrimination Act and the Race Relations Act. The High Court judgment by Mrs Justice Dobbs found that NICE "failed to avoid discrimination against the relevant groups," including people with learning disabilities and those whose first language is not English, despite having been warned numerous times that this was a serious problem. For a public body to act in this way is alarming and cannot go unchallenged. That the Alzheimer's Society was prepared to make that challenge means that, in our estimate, 25 000 people will now have equal access to effective treatments.

Our campaign was based firstly on the experience of people with dementia and carers and secondly the clear view of clinicians and

the Royal College of Psychiatrists that early diagnosis and treatment of dementia is crucial. Early intervention is the key to putting people in control of their condition and enables them to access the information and support they need.

In addition, the Mini Mental State Examination does not provide an accurate assessment of severity of dementia. There is currently no accurate diagnostic tool for Alzheimer's disease, and until then a clinician's judgment will always be more significant. NICE recognised this separately in the dementia care guidelines it published on the same day as the disputed drugs guidance.

It would be very disappointing if the disagreement about Alzheimer's drugs distracts attention from the excellent NICE dementia care guideline—which we trust clinicians and commissioners will implement as quickly as possible. We also hope that the restriction on drugs will not detract from progress made by clinicians in diagnosing dementia. **Neil Hunt is chief executive of the Alzheimer's Society** nhunt@alzheimers.org.uk