

FROM this week, NHS hospitals in England are allowed to advertise to attract patients, and can even use testimonials from celebrities to do so. Here, DR JONATHAN FIELDEN, chairman of the British Medical Association's consultants committee, explains his concerns about the changes.

WHAT would you rather have from your hospital: a glossy brochure with pictures of nice rooms and the Beckhams' walking out of the wards, or for it to be able to perform 60 extra hip replacements?

It may seem a facile question but Health Minister Ben Bradshaw's opening up of advertising raises many concerns for me and my colleagues at the British Medical Association. Healthcare and patients may well suffer in the long term.

Hospitals may close, patients may be directed to inappropriate institutions for their particular condition and hundreds of thousands of pounds — which should be going into patient care — will be ploughed into showing off health trusts' 'hotel' aspects, such as the rooms, food and even the parking.

Already, the Government has stated that the health department will allow nearly £600,000 to be spent on newspaper and radio advertising per health trust.

That's a substantial sum even for a larger than average trust, and could pay for around 30 nurses, run several wards and replace about 60 hips.

But it's not simply a question of 'wasting' money on advertising. The new code also permits NHS trusts and private treatment centres to compete for business by claiming superior results from surgery or lower incidence of MRSA infection.

From this month onwards, information will be placed on the NHS website showing waiting times, infection rates during non-emergency surgery, and surveys of patients' views on treatment quality.

While I agree that every patient should have access to this kind of information, it's by no means the most significant data a patient should be taking into account when choosing where to be treated.

Statistics are notoriously inaccurate. Mortality rates, for instance, can easily be misinterpreted. If the local population around one particular hospital is elderly, naturally more people will die there.

The surgical teams may be superb but for that very reason, they may attract the most complicated — and therefore risky — cases.

Both reasons will skew the mortality rates for that hospital even though it may be first rate. Wait-



Picture: GETTY

Costly: Hospitals' advertising spending could affect staff numbers

Why is the NHS wasting money on advertising?

Good Health VIEWPOINT

ing lists are another example. Just because a hospital has a short waiting list, it doesn't mean it is more efficient.

In fact, the opposite could be true. The most popular, efficient, safe hospitals in the country might have the longest waiting list because everyone wants to go there.

So if it's not MRSA incidences, waiting lists and mortality rates, what *should* patients be basing their decisions on? And what should the Government be spending money on when it comes to 'choice'?

While it's not as glamorous as showing off luxurious rooms or restaurants, money needs to be invested into patients having *informed* choice on proper clinical grounds. Outcome data — how well patients do when discharged from hospital — is crucial.

Money needs to be invested in the collation of that clinical data — which is often difficult to come

by because it simply hasn't been a focus for hospitals.

Patients are supposed to have had some choice since January 2006. It was limited initially to at least four local hospitals, but has been extended to include all foundation hospitals — but before 1990 you could go to any hospital in the country, so I'm not clear why this is being trumpeted as a major gain.

Despite what the Government says, very few patients want to exercise their choice to be treated at a different hospital from their local one. Most of us want to be treated as close to home as possible.

Mr Bradshaw's officials have blamed GPs in some areas, saying they have done little to promote choice. A survey in March 2007 found only 48 per cent of recent patients could remember being given any choice. This fell to 44 per cent in November.

But one could argue that a local GP, who is familiar with the local hospital, is able to filter complex clinical information for his patients and recommend the best surgeon for an operation. Why offer a patient choice if they've already been offered the best?

The move to introduce commercial cut and thrust into the NHS was foreshadowed when Tony Blair was prime minister.

Now, the speed at which it has been implemented under Gordon Brown suggests the Government is keen to use the forces of competition to improve hospital services.

My question is simply this: are health services really the right place for competition when, by its very nature, there are always winners AND losers?

Surely the reason why all political parties believe the NHS should be funded by taxation is because that allows clinical needs to be put first — not profit.

■ INTERVIEW: JILL FOSTER

Radio 4 presenter Rory

RORY MORRISON is the voice of Radio 4, reading the news and shipping forecasts. Four years ago, he was diagnosed with a rare form of cancer. Here, for the first time, he talks about his illness...

MY TENTH wedding anniversary is very clear in my memory. My wife, Nikki, bought me a beautiful single red rose and wrote a poignant and moving letter to go with it. Half an hour later, I was told I had an incurable and invariably fatal type of cancer.

These moments are never easy but it did seem a particularly cruel time to hear such news on what should have been a day of celebration for us and our two young children.

A cancer diagnosis is often seen as the end. The end of life as you knew it; the end of those hopes and dreams you have yet to fulfil; the end of normality. But as I was to find out, it's just the beginning.

To start with, there was a new and technical vocabulary to get to grips with. I had, the consultant said, Waldenström's macroglobulinemia.

As this obviously made no sense at all, he qualified it by saying it was a rare type of non-Hodgkin's lymphoma. He might as well have been talking in Martian.

The strange truth was that I had a type of cancer that defined itself by what it was *not* rather than what it was, a type of cancer that I couldn't spell let alone pronounce (deeply embarrassing for a Radio 4 news reader) and a type of cancer that was very unusual in a man of my age (I was only 39; the average age for this diagnosis is 63).

It's a cliché, I know, but you really do find yourself asking: 'How long have I got?'

'Your lymphoma is low grade, so it's not immediately life threatening, but it is life limiting,' came the reply. Stripped of consultant-speak, that apparently meant I had somewhere between five and seven years left.

As a cancer of the lymphatic system, WM involves the massive over-production of a certain type of lymphocyte, or white blood cell, in the bone marrow. In normal circumstances, these cells are a key part of the body's ability to fight infections.

These lymphocytes in turn manufacture industrial quantities of an antibody known as IGM, the largest antibody molecule the body produces and very definitely the villain of the piece. As more and more of this stuff is churned out, the blood gets thicker and thicker and struggles to circulate.

The past year started to make sense. Getting out of bed in the morning was a real struggle, and I'd done enough early starts for the Today programme over the past ten years to know it wasn't just the ungodly hour (my alarm was usually set for 3.45am!).

I'd started to suffer from a range of allergies that had previously never affected me, including hay-fever. My news reading took on a horrible nasal quality.

'Has Rory got a cold?' friends who'd heard me on-air would ask. Radio news had just moved into new offices and studios at Television Centre, and as I prepared to read each hourly news summary I cursed the new air-conditioning, convinced it was responsible for my permanently blocked nose.

I tried numerous decongestant nasal sprays and even squirted what felt like gallons of sea water up my nose to no avail.

Every morning I woke up feeling hungover and went through my days with that 'one step removed from reality' feeling you get when you've got a head cold — as if you're viewing the world through a fish tank.

Simple tasks, such as helping my son, then three, get dressed or doing the school run left me feeling ridiculously tired. Although I didn't know it, my immune sys-

By Rory Morrison

tem was in serious trouble and my blood was becoming dangerously thick.

The crisis point came in Portugal in 2004. We were on holiday with a group of friends and their families; the sun was shining, the children were happy and there was lots of good food and wine.

But my body was beginning to shut down.

The combination of the heat and the effort of playing on the beach or in the pool with the kids left me utterly exhausted.

Nikki complained that she had lots of photos of the other dads in the group with our children, but none of me.

This was because I kept disappearing to take naps and dropping into coma-deep sleeps that could last for two or more hours. I was also having dreadful stomach problems, with abdominal cramps and constipation.

I remember remarking at the time that if this was what it felt like to be 40 — I was two months shy of that milestone — it was bloody awful.

On our return to the UK, the problems with my digestion were so severe I went to the GP.

Have I mentioned that I don't like needles? I have always been terribly squeamish; the slightest hint of the red stuff and I would collapse into a dead faint.

Most embarrassingly, I remember waking up on the floor of my local health centre a few years previously with two worried nurses staring at me, probably wondering why such a big strong boy was actually a quivering wimp.

FOR the belonephobic (those with a fear of needles), there can be no worse cancer than this: diagnosed with a blood test (there have been scores since), it is then confirmed with a bone marrow biopsy — a huge needle plunged into the spongy stuff in the middle of my hip bone (believe me, there's nothing irrational in fearing that).

The first treatment — plasmapheresis — involved inserting a needle so large it required a local anaesthetic. It appeared that, like it or not, I was about to be cured of this little phobia.

Plasmapheresis is designed to thin the blood that's become thick with high levels of IGM antibodies.

My blood was passed through a large centrifuge, which separates out blood cells from the plasma fluid, which contains the IGM.

As the blood runs through the

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