Self-regulation in the independent sector

Sir,

Dr Robert Hangartner makes some interesting points in his editorial on self-regulation in the independent sector (Vol 61(3), 2000, p. 158). One of the most striking features of the UK health-care system is the degree of divorce between the public and independent components of that system.

Although the private sector is small relative to other European countries, its links with the public sector are considerable because a major component, medical consultants, work in both health-care sectors. Furthermore, depending on health-care policy nationally, large numbers in certain groups, for example older people, those with mental illness, learning difficulties and those requiring termination of pregnancy, experience health care in the private and public systems. More communication between the sectors, as well as a national ethos of viewing health care wherever delivered as part of a whole system, will benefit the whole population.

The components of a quality service outlined by the Department of Health are clinical governance, professional self-regulation and lifelong learning. Although linked through an important common medical workforce, it is unknown whether the complex events leading to failures in clinical governance in the public sector could or have been exactly mirrored in the independent sector. There is a fundamentally different relationship between the consultant and the hospital and between peers, in the private sector. Likewise, the influence of the insurer is considerable and is increasingly being used to effect requirements of clinical quality. While the natural history of lapses in clinical governance are not likely to be identical in public and private sectors, nevertheless attention to standards, audit, teamwork, management support and a culture of openness and learning will be important in delivering quality of care in private health care, as in the public sector.

Professional self-regulation is being led by the General Medical Council (GMC) and a recent added dimension has been the proposal of the Chief Medical Officer to instigate referral centres for poorly performing doctors. This is aimed at the NHS and offers a more speedy referral route and process for resolution of disputes concerning poor practice. At the moment this process is placed before that of referral to the GMC itself. When the process comes into practice, it is important that it is extended to the independent sector, and the communication between sectors ensures that health authorities, insurers and all relevant hospitals are informed when a doctor who practices in both sectors has been referred into this system.

Although there are some unique features of private health care that require urgent regulatory attention, the main aspects of hospital regulation are similar in both public and independent sectors and it is important that a consistent process is pursued in both for the benefit of the population. There is no reason to believe that the NHS attains higher hospital standards than many independent hospitals or conversely that both sectors are not facing similar challenges.

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Hypertension secondary to Marfan's syndrome

Sir,

I would like to commend Drs Khin-Maung-Zaw and Driver for their presentation of a most interesting case (Vol 61(3), 2000, p. 214). I do feel, however, that there is a philosophical difficulty in their view that the patient's psychiatric symptoms could be explained by his physical disorder: all that they have shown is that the patient had mild mitral valve prolapse in association with Marfanoid features and I am not sure that this justifies their assertion that he had 'organic illness manifesting as apparent psychiatric symptomatology'.

The great majority of people with mitral valve prolapse have no psychiatric symptoms at all — is it not much more likely that their patient happened to have two conditions simultaneously? Psychiatrists, for some reason, sometimes seem to find it hard to accept that patients can have physical and psychiatric disease at the same time and that the two may be unrelated; for my part I find it hard to see how mild mitral valve prolapse could lead to all of the psychosocial difficulties from which this young man suffered.

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Sir,

Anxiety is a common cause of raised blood pressure — so-called white-coat hypertension whereby a patient's blood pressure rises when they are due to be seen by physicians is ubiquitous. However, the key message we wished to convey was that physical symptoms of psychiatric disorders should not be dismissed as merely reflecting their psychiatric condition. Physicians tending for such patients should ensure they are appropriately and thoroughly investigated. Our patients fulfilled the World Health Organization diagnostic criteria for generalized anxiety disorder with additional features of a phobic anxiety state. He also had Marfan's disease. Our point is that our patient defied Occam's razor and had both conditions. We believe Dr Fisken has missed our point entirely.

It is our honest and humble attempt at reminding every medical doctor, including ourselves, of the importance of not discounting either physical or psychological causation of the presenting symptoms of our patients. If we do, we do so at our own peril. It is of secondary interest that our patient's anxiety state improved using a β-blocker but as we know, it is usually the somatic symptoms of anxiety that respond to such intervention.

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Correction

In the article Snoring: recent developments (Vol 61(5), 2000, p. 330) the wrong figure was used for *Figure 2*. The correct figure is reproduced below. We apologize for any confusion or inconvenience this may have caused.

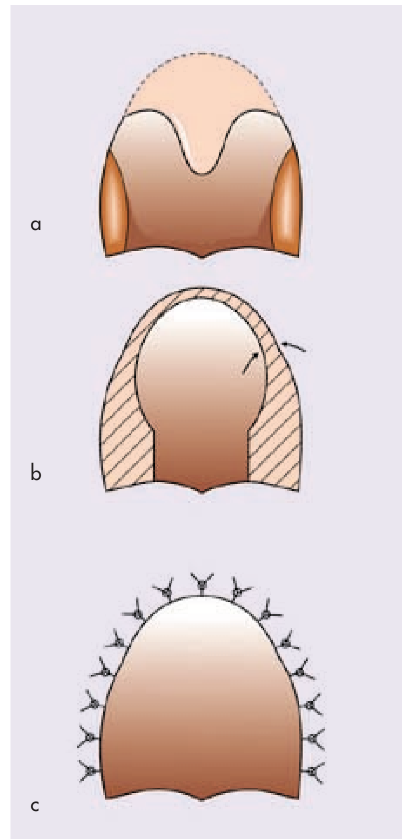

Figure 2. Uvulopalatopharyngoplasty. a. Tonsillectomy. b. Excision of uvula and rim of soft palate. c. Apposition of mucosal edges.