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Dear Mr Gething

The last Substantive Consultant in Adult Psychiatry in North West Wales, Dr Sumit Chandran, has handed in his notice.

Four years ago all consultant posts in the NW Wales mental health service were filled with Substantive Consultants, several of whom said that were they to win the lottery they would work in the Hergest Unit for free. Now all posts are locums barring Dr Gutting in old age psychiatry. The situation in General Practice locally is similar with Partners dropping like leaves, leaving hired doctors in their place.

Provided the boxes are being ticked by someone, some managers do not seem to see a problem. But it's the difference between having a Partner in a marriage and one-night stands, between being looked after by a committed parent and being in an orphanage. It's the difference between having someone who makes a commitment to a service and to developing it and providing continuity of care as opposed to someone who picks up pay for packets of care, and box ticks to ensure data continuity.

It's also the difference between double the care for half the pay or double the pay for half the care.

Four years ago, when we had a full complement of staff, the Hergest Unit had the lowest bed usage rates in Wales and possibly the UK. BCUHB missed an opportunity to trumpet a good practice message perhaps, because as evidenced by a recent reply to ITV (attached), they don't seem to know the number of people in the Hergest catchment area or the way beds in the unit are allocated. The response to ITV fits a pattern of seeing the Hergest Unit as being portrayed as a weak link, when it's been just the opposite.

But the occupancy figures should still tell you a story. Despite having the lowest number of beds per head of population in Wales, and perhaps the UK, we always had free beds and took in patients from elsewhere in N Wales and England. Now the same service, populated by locums, is permanently full. I am unable to admit my patients, and the service regularly sends patients to Yorkshire or the Isle of Wight, at an estimated cost of £1 million per annum. This was predictable once the focus switched from continuity of care to continuity of data. It is not a result of increased demand on the services or a failure of social care.

Patients don't know the doctors they are going to see from one week to the next. Nursing staff don't know the names of the doctors in the Unit. Nor do I. This wasn't inevitable. We have colleagues keen to return to substantive locum posts, at half the cost of the agency locums being employed, but management seem unwilling to let this happen.

While there are excellent locum doctors, as Dr Chandran will be, doctors sitting on Mental Health Review Tribunals in N Wales hear the details of patient moves from home to Yorkshire and back, and see these patients in some instances being managed by unqualified staff, and subject to alarming treatment options but cannot draw your attention to the problems because of their MHRT role.

Some colleagues say the problem is the NHS is not prepared to put enough money in, but four years ago I put it to the then Acting CEO of BCUHB he could run a better service on far less money. I've repeated the offer to other Board members since. I hesitate to add to the advice you undoubtedly get as to what is going on but whatever advice you're getting isn't working. I can see nothing in the notes from Andrew Goodall's session here in North Wales on September 2nd that holds out hope. And the latest and last retirement deserves marking – hence this letter.

The background for the points below comes from "Pharmageddon" a California University Press book and from a further book currently being edited. Pharmageddon was written in 2008. On the surface it focuses more on US healthcare but was written primarily with the NHS in mind. It describes a series of forces that I predicted then would result in the situation we have now.

Three decades ago in both private systems, as in the United States, and public systems, as in the UK, doctors functioned as intermediaries. Both funders of health systems and patients turned to doctors and nurses as the people who knew how to do the medical job and at the same time keep costs in reasonable control and patients reasonably safe. Both funders and patients were satisfied, some rogue doctors aside, that they were getting a reasonable deal. A much smaller cadre of managers was needed to run this system.

Two decades before that, the 1962 amendments to the US Food & Drugs Act had introduced randomized controlled trials (RCTs) as a gateway to the introduction of drugs to the market. Because of this RCTs ended up being conducted on an industrial scale. By the mid-1980s there were sufficient RCTs across many branches of medicine for physicians and others to think about creating evidence-based standards of care or guidelines.

The emergence of standards of care roughly coincided with the switch in the United States from fee for service to HMOs and with the Conservative government's reforms of the Health Service in the UK. The outcomes – growing patient alienation, rising discontent among coalface staff and rapidly escalating costs – hit the US before arriving here but have been the same in both private and public systems, which argues for the centrality of some other driving force than a commitment to private or public funding systems.

Put simply, all of a sudden managers, in private and public systems, were presented with standards of care which appeared to bypass physician discretion. They could see what the supposedly optimal treatments were and these came with a message that even though they might be the latest and most expensive treatments their use would lead to a reduction in costs, a reduction in variation across treatments and better quality, all at the same time.

It became the job of management to ensure that clinicians adhered to these standards. But this arrangement hasn't led to quality outcomes.

Part of the problem is that the standards to which your service operates as they apply to on-patent drugs are literally junk. Close to 100 % of the RCTs that have gone into their making are ghost-written. The ghost-writers do a good job – regularly portraying treatments that don't work and are harmful as safe and effective. Beyond that, 100 % of these trials have their data sequestered so that not even the MHRA in this country or FDA in the US has or has seen the data.

As a result huge amounts of money are spent within the NHS on treatments that cannot save lives or return people to work or even return them to good functioning. Treatments that are much more likely to lead to sick leave, disability or impaired functioning at work, and in the case of the elderly much more likely to leave them needing costly social care, at risk of premature death and a poorer quality of life. Pharmageddon tried to draw attention to this.

But there is a further aspect to the problem. You might be inclined to put the ghost-writing and data sequestration down to the scurvy knaves that run the pharmaceutical industry and figure there is not much you can do about that. The problem is more profound. It will need a political intervention to make a difference.

When DDT was discovered, the Swiss scientists involved quite happily doused themselves in it. In the 1940s it was used widely on troops, and sprayed on people lined up in cinema queues or for football matches. DDT was safe and effective. It deloused people and saved lives. But the metrics for judging whether it worked and was safe were based simply on its acute effects, given in a standardized way. We later discovered that chronic exposure and unexpected modes of intake produce an entirely different picture.

Even if RCTs were run by angels, they too just look at the acute effects of chemicals given in standard ways. We have forgotten this and are producing a growing number of DDT equivalents. Based on RCT claims of safety and efficacy, these treatments are built into standards that make it close to impossible to withhold treatments based on a concern for what the chronic effects might be or effects stemming from intakes mixed with other drugs. We poisoned the environment based on an apparently rational use of DDT and we are now doing something similar in the services you are responsible for.

This was brought home for me recently when I fractured my collar bone. You'll be able to see this was a significant break. It needed to be plated rather than just left to heal naturally.

In a wonderful example of the healthcare we all want, I had the bone plated hours after it broke on a Friday and I was back in work on Monday, without missing any time. This is NHS care that pays for itself.

Shortly afterwards however I had a linked experience that illustrates what is bankrupting you. An Osteoporosis Screening Clinic picked up the fact that a 60 year old had a fracture and sent me a letter. They paid no heed to the fact that I was male, fit and healthy or that the fracture had resulted from a severe impact that would have broken the collar bone of a 20 year old. I was now at risk of being put on a bisphosphonate drug. While my risk was relatively low because I could see this was ridiculous, the point of concern is that you employ a large cadre of people who screen without discretion and then run clinics that do harm.

This operation is justified on the basis of short term RCTs that claim these drugs work. But some of the headline bisphosphonate trials appear to have been fraudulent and beyond this they weren't geared to pick up the fact that once these drugs are administered for years they increase rather than reduce the risk of clinically significant fractures, and produce a range of other debilitating problems. In addition to creating other illnesses, the availability of clinics and screening creates the illness it seeks to treat. When I was training in orthopaedics, clinical osteoporosis was a vanishingly rare condition. Now up to one third of women over 50 are told they have it with many put on drugs that do more harm than good.

This is not a criticism of the services here which I suspect operate with more discretion than most. The point is you will just think of something like the creation of osteoporosis in terms of the cost of the drugs, while you are also funding staff, clinics and screening tools, and an increasing number of managers to ensure standards of care in this area, along with non-mental health illnesses, and non-cholesterol disorders, and other non-conditions are met.

Put another way you could probably pay the pharmaceutical industry as much as you pay them now for perhaps 20% of the drugs they give you and still save money provided companies agreed to start marketing for non-conditions. You'd make the savings from eliminating osteoporosis screening clinics and related expenses covered below, the more general costs of treatment induced disability, your locum bill, and rising managerial costs and the degradation of care that goes with all of these.

In adolescent mental health, the standards are pushing children toward drug treatments even though we know that pretty well every single trial has been negative. We end up with drug options because wisdom and other non-drug options are not readily evaluated through RCTs and as a result sensible options don't make it into the standards.

The selling of antidepressants for teens promised a public health benefit – less crime, alcoholism, substance abuse, divorces, career failures, suicides. But in fact these drugs increase suicidal events, alcoholism, violence, divorce rates, and career failure.

This is not a surprise. The testing procedures to get them on the market are ones that alcohol would have sailed through. It is no surprise that the public health consequences have been rather similar to letting alcohol on the market and allowing it to be promoted heavily – for free if built into standards of care - so that roughly 10% of the population are now taking these drugs chronically and cannot stop.

These are not issues for Cinderella pockets of your service like osteoporosis clinics or adolescent mental health services alone.

- They apply to antibiotics where the fluoroquinolones show DDT levels of toxicity in acute care but yet are often used frontline because of dangerous marketing and because of antibiotic resistance which may yet bring most surgery to a halt.
- They apply to anaesthetics where anaesthetists seem relatively oblivious to the longer terms consequences of the drugs they give.

- They apply to maternity services where the fluoroquinolines and antidepressants increase rates of birth defects and the antidepressants are contributing to an epidemic of Autistic Spectrum Disorder.
- They affect your cancer services when beds cannot be found for an Elective patient owing to the beds being filled by an antidepressant linked suicide attempt or a bisphosphonate fracture. It might sound reasonable to put an Elective patient off – but there is not much "Elective" about being on chemotherapy for cancer.

Across swathes of medicine you have been led to believe that replacing variation with uniform best quality approaches will deliver the right outcomes. It won't. The ability to distinguish between superficially similar clinical patterns and the discretion to know when to take risks with poisons – or mutilation as in my shoulder - are needed to get the right outcomes. But in the face of a clear failure of policies, your services have turned to ever more adherence to protocols, ever less discrimination and discretion, and ever more audit trails in order to nail down responsibility when things go wrong.

It is the replacement of discretion by management that has led other colleagues, and now Dr Chandran, to leave. If we are not being listened to, why stay for half the pay? But you cannot replace discretion by management, at this point in time anyway. It cannot and doesn't work.

Management rhetoric still supports clinician involvement in governance but a culture of bullying and harassment belie this. Having had 25 years of no problems with management, in 2013-14 there were more than 10 efforts by management to have me reviewed or suspended, along with a referral to GMC. HIW appear to have been complicit in this down to collusion in a creation of non-existent events. There have been three processes since, some quite ludicrous, along with a further referral to GMC and further efforts to review me. None of these have come from patients or their families. All originate in a management who have claimed to be willing to listen but who respond with reprisals. It's too early to say whether a recently installed management are cut from the same cloth but current planning does not seem to recognize the problems outlined here.

In the face of this healthcare winter, a range of solutions have been aired in recent years from a greater turn to academic physicians (like me), along with nurse prescribers and physicians assistants.

It is not an unreasonable move to think that if the drugs are as good as is claimed and as free of problems and healthcare is just about prescribing that nurses or others could do the job as well for half the cost and would be more likely to adhere to guidelines while doing so. There is no doubt that nurses can do a great deal of what doctors once did and that extends to an exercise of discretion – knowing when to deviate from guidelines. But the nurses that are good enough to operate in this way are going to come up against the system now in place and will come to grief, as will physicians assistants. Both are less well placed than doctors in terms of defence organisations and other supports to deviate from the standards of care, and are less likely to do so when needed as a result. This will aggravate rather than solve your problem.

Part of the reason the Hergest Unit has kept functioning has been down to an extraordinary cadre of nursing staff – some of whom have had to cope, as I have, with being harassed or even dismissed on the basis of events invented by management, selectively directed it would seem at staff who raise safety concerns. Outside the Hergest Unit, the pressures have led to some community mental health teams close to evaporating with well over half their staff on sick or related leave.

Efforts to promote more academic physicians will get you at best half the amount of work for a full pay packet. Perhaps even less as most academics work hard on reducing their clinical input, and because academics on average are probably less good clinicians – they have less of the hands-on contact that generates an ability (in staff who are not too bogged down in paperwork) to recognize clinically important patterns.

You may well get more grief as some of them, like me, with time on their hands, will start raising concerns like the ones I am raising here. Worse again, many of the rest will get involved in standard setting and encouraging management to think that the problem is the family doctors and non-academic specialists who deviate from standards.

None of these options solve a problem that gets framed as a risk management problem once standards of care come into the frame, especially if they are junk. Medicine tries to bring good out of the use of a poison or a mutilation – if it cannot eliminate the circumstances where these are needed. It is inherently risky and the risks are, it is now clear, aggravated rather than eliminated by standards of care and related risk management processes. The risks are handled by hanging on to good people who Eat risk for you. Dr Chandran was exemplary in this respect. But he and others, both doctors and nurses, have vanished from North Wales' mental health and I suspect equally good medical and nursing staff have been leaving other areas of the service.

This isn't a problem for you alone to solve. We physicians clearly risk doing ourselves out of a job by playing along with the current system. If there are cheaper prescribers who needs us? This is the reason I have copied the President of the Royal College of Psychiatrists on this letter. I've also copied in the Chair of the Senior Medical Staff group here, who is worried about services being stripped out of Ysbyty Gwynedd and is calling for more capital investment – the wrong call in my opinion.

It is not going to be you alone who can get us back to a position where there is some recognition that a significant part of the medical brief is being able, among other non-drug options, to deploy poisons to good purpose, and that to do this safely a service needs good and committed people, in an ongoing relationship with the people they poison or mutilate.

There are other big funders from the HMOs and insurance companies in the US to state supported insurers in Europe who have an equal interest in making this "market" work. At the moment you are not getting what you pay for – treatments that improve productivity and enhance quality of life. Unlike any other market where products improve year on year and costs fall, you are uniquely getting products that cost more but in many instances are less effective and more dangerous yet end up as the favoured option on the latest standard of care.

Going back to the medical paternalism of the mid-1980s is not an option but unless some politician gets to grips with how efforts to put things right, put in place with good intentions, can in a few short years contribute to transforming what was the best mental health service in Wales into a failing service, this problem isn't going to get solved.

Yours sincerely

David Healy

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cc. Guto Bebb MP, G Doherty, Professor S Wessely, Dr C Thorpe.