By Dr Grace Yang

Working in the National Health Service in UK

It was 5pm on a Wednesday afternoon, and I had just clerked in a new admission. Mrs Achomi was a 42-year-old African lady with chronic renal failure on dialysis for the last six months. She claimed to have been in the United Kingdom (UK) three years ago, but got married and therefore moved to Ghana to live with her husband. Over the last six months, she had needed haemodialysis for her renal failure and had come to UK to "get the kidney problem sorted out".

Her last dialysis session was on Monday in Ghana. She then got onto the plane with a temporary vascath in-situ (I still wonder how she ever got away with flying on a commercial plane with a temporary vascath) and flew over to London to stay with a friend. She suffered shortness of breath (because she was due for another dialysis session) and therefore presented to the Accident and Emergency Department on Wednesday. We gave her a dialysis session on Wednesday night for her shortness of breath, and had to call in the on-call dialysis nurse to do that.

Later in the evening, I was approached by the ward nurse. She told me I was not allowed to give her any further treatment until we established her eligibility for free NHS treatment. So I had to cross off all the regular medications we start on patients with chronic renal failure. What was more, I was told we would need to keep a record of all the investigations and treatment that we did, so that we could charge her for it if she turned out to be not eligible for NHS treatment. I dutifully started this record: blood tests for full blood count, urea, creatinine, electrolytes, calcium, phosphate, CRP, chest x-ray and so on.

On the ward round the next morning, Mrs Achomi was seen by Dr Black, the renal consultant who was covering the wards at that time. He gave us a five minute lecture on health tourists who travel the world in search of healthcare. Especially in the UK, where the NHS provides free healthcare to UK residents, there are a significant number of people who come here hoping to benefit from free medical treatment. He also told us how we need to be vigilant about spotting these patients even though we may not feel it is in our job scope as a doctor. He said we have a duty to the UK taxpayers as the NHS is funded wholly by taxpayers' money.

There was another patient, Mr Rogers, on the ward round who had secondary hyperparathyroidism as a complication of end-stage renal failure. He was also developing some signs of calciphylaxis as a result and had come to the hospital for pain relief of his calciphylaxis lesions. Cinacalcet is the recommended treatment for his condition. However, it is also an expensive drug so its use is limited to people who would benefit most from it. The National Institute for Health and Clinical Excellence (NICE) provides national guidance on the use of medicines. Unfortunately for Mr Rogers, the NICE guidelines recommend Cinacalcet for patients with parathyroid hormone levels above 85, but Mr Roger's level was only 71. Thus we cannot give Cinacalcet to Mr Roger, not until he meets the criteria set by the NICE guidelines.

These clinical encounters caricature clinical practice as a doctor working in the NHS. The National Health Service, or NHS as it is more commonly known, was set up in 1948 to provide healthcare for all citizens of UK. Over the years, there have always been changes to the way healthcare service is provided but the founding principles of the NHS have always remained at its core. These core principles can be summed up as "the provision of quality care that meets the needs of everyone, is free at the point of need, and is based on a patient's clinical need, not their ability to pay".

The principles are laudable. However, limited resources means that healthcare has to be rationed – the basis of rationing is clinical need. On one hand,

Page 31 ▶

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◀ Page 30 – Working in the National Health Service in UK

a 35-year-old man with cystic fibrosis who needs a heart-lung transplant is able to receive transplant surgery, life-long immunosuppressive medications and follow-up care even if he is unable to afford it because it is all free – he needs it in order to survive. On the other hand, an 85-year-old lady with disabling osteoarthritis of the hip has to wait for months before getting hip joint replacement surgery, even if she has paid towards the NHS through paying UK taxes all her life – her condition is not life-threatening.

It also means that we need to protect against abuse of the NHS by people who are not eligible for free NHS treatment. It turned out that Mrs Achomi was one such person who was not eligible. So after giving her life-saving emergency treatment, we sent her away with details of a local private dialysis centre.

Three days later, late at night, she presented again to the Accident and Emergency Department with severe shortness of breath due to fluid overload. She had not gone to the private dialysis centre that we gave her details of. We were not sure if we were allowed to treat her. She pleaded with us: "Please, I am dying. Can you just stand there and watch me die without doing anything?" We had to treat her so we brought her in for emergency dialysis, and we called in the on-call dialysis nurse again.

On the ward round the next morning, it was still Mr Black covering the wards. He gave us another 10 minute lecture on the considerations we have to give to financial cost to the NHS incurred by the decisions we make. On one hand, we should not be treating a patient who is not eligible for free NHS treatment. However, we are always obligated to give life-saving emergency treatment and the treatment of Mrs Achomi has incurred the cost of unnecessary inpatient stays and calling out of the on-call dialysis nurses. So Mr Black was very pragmatic about it, and offered Mrs Achomi life-preserving twice weekly dialysis rather than the usual thrice weekly dialysis that all other patients receive. She also did not receive renal medications like phosphate binders or statins.

The next week, Mrs Achomi presented yet again to the Accident and Emergency Department at night. She had gone to the dialysis unit earlier in the day demanding dialysis even though she was not due for it that day. A consultant had assessed her and decided that she was not in pulmonary oedema and therefore sent her home and asked her to return on the scheduled day. She came later that night short of breath and wanting dialysis. Once again, we had to admit her for out-of-hours dialysis overnight. Yes, and we had to get the on-call dialysis nurse in again.

The consultants had changed around and Dr White was the doctor covering the wards now. On the ward round the next morning, Dr White had a different view from Dr Black and gave us a lecture on how her management had been ridiculous. He told us about how severe poverty was in the African countries, and how affluent countries like UK should be helping them rather than being so miserly in our attitude. You could hardly blame Mrs Achomi for taking desperate measures for the sake of her own health.

I am not sure which view to take – things are not always black and white, are they? At least I do not have to make such decisions as a junior doctor but working in the NHS has certainly helped me to think about such issues. ■