

The misuse of the term *treatment* to cover the role of secondary care

The misleading use of the term *treatment* as a blanket term to cover the different (though often complementary) outcome components that comprise secondary care, is perverse to the point of suggesting an intention to misinform. Given that *treatment* in a healthcare context is “the administration or application of remedies to a patient or for a disease or injury; therapy,” its misuse in draft guidelines that studiously disregard the importance of the investigative and diagnostic role played by secondary care, deceptively implies by default that this role is not also jeopardised in denial of access to free secondary care. To illustrate the importance of investigation and diagnosis in secondary care - chest pain is experienced by 20-40% of the general population during their lives, and accounts for up to 1% of visits to GPs, 5% of visits to emergency departments and up to 25% of emergency admissions to hospital, yet cardiac disease only accounts for 8-18% of all cases.

Whilst the meaning of *treatment* as used in the draft National Health Service (Charges to Overseas Visitors) Regulations 2010 is defined in the interpretation section (page 3) as including “the prevention or diagnosis of illness” and “diagnosis of symptoms or signs occurring for the first time after the visitor’s arrival in the United Kingdom” *, not only is *investigation* never mentioned and *diagnosis* thereafter conspicuous by its absence, but virtually nobody will ever read the document anyway. More importantly, in the draft **NATIONAL HEALTH SERVICE GUIDANCE ON IMPLEMENTING THE OVERSEAS VISITORS HOSPITAL CHARGING REGULATIONS** which will be read, *diagnosis* is mentioned three times but there is no explanation of the often complicated process required to achieve a diagnosis. While *investigation* is mentioned seven times, it is, Kafka-esquely, only in the context of determining someone’s entitlement or if a criminal act has taken place. The dearth of the terms *diagnosis* and *investigation* generates a misapprehension that patients arrive in secondary care with pre-established or obvious diagnoses promptly assessable as requiring treatment that is either immediately necessary, urgent, or neither.

A diagnosis is the result of the process of determining the nature and circumstances of a diseased condition, and comprises three distinct stages: firstly an analysis of the significance of symptoms in the context of each patient’s medical history, secondly an analysis of the significance of the findings on physical (or mental) examination of the patient, and thirdly an analysis of the significance of often pivotal investigations that in many cases are only accessible within secondary care. Subsequently a final analysis that takes account of how the circumstances of the patient influence which treatment should be recommended, leads to a discussion with the patient (assuming intact mental capacity) leading to a mutually agreed decision as to what treatment, if any, is most appropriate. Thus the role of secondary health care is not only to treat but also to diagnose/exclude conditions that cannot be diagnosed/excluded and/or treated in primary care (and do not need to be diagnosed/excluded and/or treated in tertiary care).

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In the training of doctors it is often taught that the three most crucial aspects to medical practice are diagnosis, diagnosis and diagnosis. At one end of the spectrum even the most critical and obvious emergencies can necessitate complex and time consuming investigations to identify an underlying precipitant - for instance status epilepticus could be due to metabolic, malignant, endocrine, respiratory, cardiovascular, infective or toxicological causes - or indeed to more prosaic causes such as constipation or poor treatment compliance. At the other end, something as banal as a mild change in bowel habit can herald the presence of widespread metastatic bowel cancer also requiring multiple sophisticated and sequential investigations.

One of primary care's defining roles is to refer patients for a diagnosis, which usually means for investigation. NICE harbours no illusions as to the importance of investigations in the management of disease. Over one in four deaths in the UK is due to cancer and, like the Charging Regulations, NICE has developed a hierarchy of urgency guidelines regarding referral for investigation and treatment for suspected cancer. They are ranked as i) immediate: an acute admission or referral occurring within a few hours, or even more quickly if necessary, ii) urgent: the patient is seen within the national target for urgent referrals (currently 2 weeks), and iii) non-urgent: all other referrals. Also, NICE exhorts GPs to refer patients urgently for conditions that defy diagnosis in primary care but could possibly be due to malignancy - highlighting the uncertainty inherent in primary care of the significance of symptoms before a patient is investigated. Moreover, most disease groups other than cancer can also mandate referral requiring a hierarchy of urgency eg metabolic, cardiovascular, cerebrovascular, pulmonary, gastro-intestinal, infectious and autoimmune.

The importance of explicitly recognising the significance of the indispensable investigative and diagnostic role of secondary care is that each of the major stake holder groups with regard to the denial of refused asylum seekers access to free NHS care - refused asylum seekers, healthcare workers, the government and the electorate - understand there is much more at stake in the medical management of a patient's illness than just treatment. Very often complicated investigations have to be carried out to establish a diagnosis before a treatment urgency hierarchy can be applied.

* Draft 2010 No. 000 NATIONAL HEALTH SERVICE, ENGLAND National Health Service (Charges to Overseas Visitors Regulations 2010. P 3-5

“treatment” includes medical, dental and nursing services required for— (a) the care of women who are pregnant or in childbirth; or (b) the prevention or diagnosis of illness;

“treatment the need for which arose during the visit” means—

- (a) diagnosis of symptoms or signs occurring for the first time after the visitor's arrival in the United Kingdom; or
- (b) treatment which, in the opinion of a medical or dental practitioner employed by or providing services to, the relevant NHS body or NHS contractor, is required promptly for a condition which—
 - (i) arose after the visitor's arrival in the United Kingdom; (ii) became acutely exacerbated after the visitor's arrival; or
 - (iii) but for the treatment would be likely to become acutely exacerbated after the visitor's arrival.