



## EDITOR'S CHOICE

## Old problems, new models

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The BMJ

With the NHS registering ever worse financial figures (doi:10.1136/bmj.i2904) and GPs seeking a ballot on industrial action (doi:10.1136/bmj.i2900), few could argue that things are going well with England's health service. In such dire times we need people willing to speak truth to power (doi:10.1136/bmj.i2822), but we also need innovators with the energy and optimism to try new ways to do things.

You will have heard about the vanguards launched last year to develop new models of care as part of NHS England's *Five Year Forward View* (doi:10.1136/bmj.h5147). Perhaps you are part of one of them. Now, on a smaller and arguably more manageable scale, comes the "primary care home." Fifteen pilot sites are providing multispecialty health and social care for populations of between 30 000 and 50 000 patients. Networks of GPs share premises and a single budget with community and social workers. As Adrian O'Dowd reports (doi:10.1136/bmj.i2922), those involved think that this model breaks down barriers and bureaucracy. Early signs are that GPs and nurses like being able to deliver truly integrated care, making it easier to recruit staff.

New models are also needed for how we present and use guidelines, say Margaret McCartney and colleagues (doi:10.1136/bmj.i2452). All too often, evidence based medicine has been reduced to the enactment of bureaucratic and authoritarian

"recommendations" that are based on population data and enforced through payment for performance contracts, they say. Even for those skilled in interpreting evidence it can be hard to take account of a patient's individual preferences and circumstances. Yet surveys show that most patients want to share decisions with their doctors or make the decisions themselves.

McCartney and colleagues call for nothing less than a global transformation in the resources available for clinical decision making. Doctors and patients need tools that encourage questions such as "What are the options?" and "What are your hopes and priorities for the future?" They say that usable decision aids should now be seen as one of the most important end products for evidence based medicine.

Their final flourish is that GPs should not be paid according to how many patients comply with guideline recommendations. Instead, when decisions differ from guidance, this should be noted in the medical records with codes such as "patient choice" or "discussed and decided." This alone might do much to restore GPs' sense of themselves as autonomous professionals rather than overworked and undervalued state bureaucrats. Because patients often seem to choose the less interventionist option, proper resources for shared decision making could also save money.