Local innovation can’t be driven from the top

PERSONAL VIEW  Martin Connor

In a recent presentation to UK physicians at Stanford University, Alain Enthoven produced a revealing insight. He had advised the Thatcher government at the outset of the internal market during the late 1980s. He had made the case that because no one understood how to manage risk in the NHS, managed competition should be piloted in some small areas first and only made a mandatory part of national policy once the lessons had been learnt. In this respect, he was ignored, and the 1989 white paper Working for Patients unrolled a phased but universal introduction of the new approach.

Ministers come and go, but the Department of Health has behaved consistently as if there were a “correct” central policy regarding structures and that its job is to experiment with the NHS while it works out what this policy might be. The sad irony might be that no centralised policy is right, and the successive restructurings are exercises in destructive futility.

The travails of Andrew Lansley’s reorganisation show how this tendency in the health department remains undimmed. With one side of its forked tongue, it says that “only locally based innovation will get us through” while its behaviour persists in managing through single model centralisation.

The closest it comes to flexibility is through pilots focused on models of care, representing “additive experiments,” such as the three telehealth pilots presently under way (http://bit.ly/mAnvOy). What is the plan if the pilots “work”? If the department performs to type, they will become mandated as part of national policy, like the Darzi polyclinics, and forced on local systems irrespective of local priorities or the local case for change.

Although the coalition has manoeuvred the Health and Social Care Bill through its third reading in the Commons, we haven’t seen any change in the centralising tendency insisting that core incentives must apply identically everywhere. Cultural insult is added to organisational injury when the department orchestrates messages that blame different NHS sectors for sclerosis and failure (“it’s the primary care trusts,” “the general practitioners,” “the consultants,” “the managers”), when it should look to its own lack of flexibility for a substantial part of the explanation.

Contrast this with the approach to reorganisation of health in the United States. Recently, the Centers for Medicare and Medicaid Services published a major set of regulations for consultation that will allow local healthcare systems to integrate primary and secondary care and benefit from a modified payment system by creating “accountable care organisations” (BMJ 2011;342:d2462). In turn, this policy has been informed by a “demonstration” project that has been running in 10 physician groups since 2005.

The need to encourage innovation is undoubtedly more urgent than ever. It will not happen in the NHS until the Department of Health is prepared to open up parts of the core programme—such as Payment by Results, competition policy, and the general practitioner and consultant contract—to modification in controlled local experiments, so that the service can start to discover what works in accordance with patient benefits and local professional culture, rather than Whitehall rules.

Why shouldn’t a locality eschew competition and pursue vertically integrated clinical networks, provided appropriate checks are in place? Why shouldn’t a group of general practitioners negotiate a prepaid capitation scheme to transfer utilisation risk to a provider or group of providers? Why can’t a group of general practitioners choose to selectively refer to preferred providers if they have taken the time and trouble to agree information sharing and quality standards with them? Why wouldn’t primary and secondary care doctors form a local group to offer a completely new type of provider?

As he reflects on the bill to reorganise the NHS, David Cameron should join those national policy makers who are prepared to allow demonstration sites to pursue local developments, even—or especially—where these may run counter to the present dominant thinking in national policy.

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A cure for the disease of hate

A Gazan doctor working in Israel describes extraordinary tragedy, with a determination that good must come from bad. Iain McClure recommends his book to all doctors.

On 16 January 2009 three Palestinian sisters were killed when an Israeli tank fired two shells into their bedroom. They were the daughters of Dr Izzeldin Abuelaish, a Palestinian gynaecologist, who, uniquely for a Gazan doctor, held a consultant post in an Israeli hospital. Abuelaish's book, I Shall Not Hate, is an account of his life up to this momentous event and movingly explains his remarkable reaction. In essence, Abuelaish, who likens hate to disease and communication to cure, has drawn on his medical experience to seek a new approach to the resolution of apparently insoluble conflict.

For the three weeks prior to January 2009 the Israeli Defense Forces had been pursuing an incursion into the Gaza Strip to eradicate Quassam rocket attacks into Israel. The Israeli government had prevented Israeli or foreign journalists broadcasting from within Gaza during the operation. However, Abuelaish, a well known public figure in Gaza, had been invited by Israeli television and radio to contribute regular live bulletins, effectively circumventing this ban, to explain the reality of his and his family's life within the war zone.

Minutes after the two Israeli tank shells struck his home, Abuelaish telephoned his friend, the Israeli Channel 10 News journalist Shlomi Eldar, to ask for help. By chance, Eldar was live on air. Israeli Channel 10 News journalist Shlomi Eldar, to ask for help. By chance, Eldar was live on air. There then followed what must surely qualify as one of the most distressing interviews ever broadcast. We watch the face of the seasoned Israeli anchorman slowly collapse, as the news of the disaster is relayed to him by his Palestinian friend. Eldar holds out his mobile, switched to speaker phone, as Abuelaish's screams of despair ring out.

In reaction to this event, relayed around the world in minutes, international condemnation escalated and the incursion finally ended 48 hours later. As many as 1400 Palestinians and 13 Israelis had been killed in just 22 days. More than half of the Palestinians killed were civilians; more than 300 of them children.

Like all tragedies, this account does not hold back from revealing the full horror of the event that led to catharsis. Indeed, unlike most tragedies, this book both ends and begins with catastrophe, and within, Abuelaish explains both his own story and that of the 60 year Israeli-Palestinian conflict.

What is most convincing in this account, as is often the case, is when the author reduces the political to the personal. Abuelaish describes his family's displacement from their ancestral lands by Israeli settlers. We hear about his parents' struggle to provide for their children in Gaza and of Abuelaish's considerable achievement, against difficult odds, in obtaining a place to study medicine at Cairo University.

Abuelaish follows his well honed instinct that good often comes out of bad, in relating the varied setbacks that he overcame while trying to build his medical career. He trained in London and at Harvard to earn his impressive qualifications, but it was in Israel that he forged the opportunity to develop his specialist clinical skills. Throughout his professional struggle, he maintains a balance by building a family life in Gaza and, most importantly for the significance of the book, by gradually developing friendships with Israeli colleagues.

Realising that "violence begets violence and breeds more hatred," Abuelaish slowly discovers why he "cannot rely on the various spokespersons who claim they act on my behalf." Instead, he learns Hebrew, developing what he believes to be the key skill of an effective doctor. He communicates "to my patients . . . and colleagues—Jews, Arabs" and discovers that "they feel as I do: we are more similar than we are different, and we are all fed up with violence."

Then events take a dramatic turn for the worse. In September 2008, three months before the Israeli incursion into Gaza, Abuelaish loses his wife, Nadia, mother of his eight children and the foundation of his stable family life, to acute leukaemia. An Israeli tank, taking position outside his house two days before it is attacked, slowly aiming its gun at his terrified family within, is a chilling omen.

What is remarkable about Abuelaish's personality, simply and honestly testified in this forceful account, is how he has combined the varied strands of his life to achieve a powerful presence that successfully confronts the banality of evil. His faith in family, his religious belief, his admiration for the perceptiveness of children, and his conviction that the medical profession is a worthy force for good, are all contributors to this.

Abuelaish concludes with his realisation that his greatest challenge still remains: to cure the disease of hatred. He does not deny the anger he feels about what has happened to him. Instead, he conducts it, into a radical "immunisation programme," which, as he puts it, will inject people "with respect, dignity, and equality," one that will inoculate them "against hatred."

Every doctor should read this book.

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MEDICAL CLASSICS

Johannes Brahms and Theodor Billroth: Letters from a Musical Friendship

Translated and edited by Hans Barkan, first published 1957

The medical humanities tend to have a physicianly hue, with surgeons perhaps unfairly labelled as less given to such reflective activities. Given that surgeons have won several Pulitzer prizes, and that the authors of the magisterial books Complications: A Surgeon’s Notes on an Imperfect Science and How We Die: Reflections on Life’s Final Chapter are both surgeons, this is an unfair rap. However, the life of a surgeon is tough, with long hours and training meshed with constant mental and physical strain. A balance of work and relaxation is essential to professional and personal life, and one of the most encouraging examples of combining high surgical achievement with a fertile artistic life can be found in this remarkable book.

Letters from a Musical Friendship is a fascinating insight into the minds of two outstanding figures in different fields: the pioneering giant of surgery Theodor Billroth (1829-94) and the composer Johannes Brahms (1833-97). In 331 letters over 29 years we see how Billroth and Brahms, men of different backgrounds with diverse manners and experiences, were drawn together by the struggles in their lives and the determination to conquer their areas of work. This symbiotic and brotherly relationship offered Brahms the poetic evocation of his friend, and Billroth musical joy in his world of life and death.

Billroth was an accomplished pianist and violinist who was guided into medicine by his mother and uncle. He was a pioneer in gastric, oesophageal, laryngeal, and abdominal surgery. Medicine was his vocation; music his avocation. He declared, “My pure love is music, but medicine courted me legitimately.” Music improved his inventive ability as a surgeon. His final book, Wer ist Musikalisch? (“Who is musical?”), offered a pioneering scientific insight into musicality. Billroth, who believed art, over science, was immortal, constantly listened to and played Brahms’s music. In turn, Brahms often appreciated Billroth’s meticulous analytical scrutiny of his compositions ahead of publication, and much of his chamber music premiered in Billroth’s house.

In the later years of their friendship, changes in temperament led to less frequent exchanges. Brahms grew more introverted and contemplative. Their relationship deteriorated sharply when Brahms was offended by the so called mutilation of the manuscript of his string quartets opus 51, which he had dedicated to Billroth: the surgeon had removed the first line and attached it to a photograph of the composer in an unappreciated act of homage. However, after six months with no communication, their friendship returned to a gentle flow of epistolary exchange until Billroth’s death. This compelling book captures the evolving relationship between two unlikely friends over a quarter of a century. It also reassures us that medicine and the arts remain close bedfellows, regardless of our medical specialties.

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BETWEEN THE LINES

Theodore Dalrymple

Life imitates literature

Simenon, like Dr Alavoine, was married to a wife whom he did not love... Simenon didn’t kill her, of course, confining himself later to mere character assassination in his books

Doctors have been murderers in literature, as in life. Among the former is Dr Charles Alavoine in Georges Simenon’s Letter to My Judge, published in 1947. The book is in the form of a letter addressed by Alavoine to his juge d’instruction, explaining why he strangled his lover. There is a short appendix, in the form of a newspaper report describing how, because of his good behaviour in prison and his professional qualifications, Dr Alavoine was given duties in the prison hospital. This allowed him access to the poisons cupboard, and he then took a fatal dose of its contents.

Dr Alavoine was not a leading light of our profession. Once qualified, he rarely looked at a medical journal, though he sometimes sneaked out of his consulting room in the small town where he practised to read his textbooks. He bought his first practice from Dr Marchandeau, who was nearly blind. Dr Marchandeau gave him a little paternal advice: “They [the patients] are almost all the same. Above all don’t tell them that a glass of water will do them as much good as medicine. They won’t have any confidence in you and, what is more, at the end of the year you’ll have earned hardly enough to pay your taxes and your subscriptions. Medicines, my friend, medicines!”

He continues, “They’re not asking to be cured but to be looked after... And above all never say to them that they’re not ill... You’ll be lost if you do.” To this day, French doctors are prone to polypharmacy.

Dr Alavoine is married to a woman whom he does not love and who does not love him. After 10 years he meets a young woman called Martine in a bar in Nantes, who has had a chequered and perhaps unsavoury past. He falls instantly and passionately in love with her, and by various subterfuges manages to introduce her into his household as an employee. Inevitably his wife discovers their real relationship, and Alavoine decides to leave with Martine for Paris.

Alavoine is intensely jealous of Martine, not because she is unfaithful but because of her past, because he is not the only man to have slept with her. Several times he punchers her when he thinks of this, and, according to him, she accepts the blows with humility. He comes to the conclusion that he must kill her to cancel out her sordid past and to return her to a state of innocence, in which their love will be forever perfect. As he strangles her, she looks at him first with fear, but then with “a look of resignation and deliverance, a look of love.”

What is alarming about this is that so much of the story is autobiographical. Simenon, like Dr Alavoine, was married to a wife whom he did not love and took a woman with whom he had a violent, jealous relationship into his household on the pretext of employing her. Like Martine, she had both a past and a large scar across her abdomen attesting to that past. Simenon didn’t kill her, of course, confining himself later to mere character assassination in his books. But it was always Simenon’s point that the dividing line between the killer and those who do not kill was much finer than usually supposed. Apparently, he knew; he was Dr Alavoine.

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Rubber love

Sometimes the greatest medical innovations are also the simplest. Take gloves. Pasteur proved his germ theory in 1857, and Lister pioneered antiseptic procedures in 1865, but surgeons continued to operate with blood encrusted bare hands for more than another two decades.

The US surgeon William Stewart Halsted (1852-1922) was an early adopter of Lister’s antisepsis regime and an enthusiastic pioneer of anaesthesia. Born and trained in New York, Halsted spent two years studying in Europe’s most progressive laboratories and hospitals, before returning home to juggle six hospital posts and a busy private practice. Keen to trial new ideas, he performed an early gallstone removal on his mother—reputedly on the kitchen table—and saved his sister when she was haemorrhaging after childbirth by transfusing his own blood to her.

His self experimental zeal nearly finished his career. Trying out cocaine as a potential anaesthetic with fellow surgeons and students in 1885, Halsted became addicted. He spent a year in a sanatorium where he emerged cured of his cocaine habit—and addicted to morphine for life. Recuperating in Maryland, Halsted was offered the job of chief surgeon at the new Johns Hopkins Medical School, which opened in Baltimore in May 1889.

Probably the least eccentric of the hospital’s so called “big four” founders (Howard Kelly was a snake collector and William Osler a practical joker), Halsted was a meticulous surgeon who operated with slow precision to minimise tissue damage and insisted on absolute hygiene. Romance blossomed with head nurse Caroline Hampton, a Southern belle who had turned to nursing when her planter family fell on hard times.

When Hampton complained in the winter of 1889 that the mercure chloride she had to wash her hands with gave her a rash, Halsted decided, “as she was an unusually efficient woman,” to ask the Goodyear Rubber Company to make two pairs of thin rubber gloves. The gloves did the trick, and soon the surgeon took the nurse’s tender hands in his.

She married him just a few months later in June 1890, although whether the pair lived happily ever after remains open to conjecture. Taking a large house in Baltimore, Mr and Mrs Halsted lived in separate wings and led separate lives. Halsted’s compulsive perfectionism (he had shoes shipped from Paris and sent shirts there to be laundered) and the morphine may have had something to do with it.

But if love wore out, the gloves did not. Although it was several more years before surgeons realised that rubber gloves protected patients as well as doctors, the practice soon became universal. And love conquered all germs, or most of them at least.

Sources: see bmj.com

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Ethics committees: an ethical dilemma

The year before we married we lived in sin, just outside Sunderland. We attempted to cook. The results were half baked, half cooked, and half eaten. Spitting food out, although not classic table etiquette, was common. But in our darkest hour we were saved by the supreme being, Delia Smith. We followed her simple recipes using our tiny, hand me down aluminium pans, and they worked. We are better cooks now and realise that cooking is as much about technique as ingredients. I still read cookbooks, but never follow them, because modern recipes demand ridiculous and pompous ingredients that you can’t buy in Lidl.

So it is with medicine. To start with, we use a reference cookbook approach. In time we discard this, because medicine too is a job of technique. But problems arise with guidelines: these complicated modern medical recipes also have ridiculous research ingredients suggested by super-specialists—ingredients that are unavailable in the discount store of frontline medicine. There is little research done in the frontline of primary and secondary care to counter the advice in guidelines. Even in hospital care, most research is done by coerced junior doctors; research for research’s sake, not research for curiosity’s sake. So much of the research published in medical specialty journals is irrelevant to the front line. Even the available research has the bitter taste of conflicts of interests of drug companies or special interest groups. But in fact research is easy: there is no need of bespectacled statisticians or fancy research design, because the value of the best research is proportional to its simplicity. All you need is an interesting observation and the right question.

So why aren’t we using the research potential of jobbing doctors? The greatest hurdle to research is ethics approval. Rightly, ethics committees seek to protect patients from threat of medical experimentation. But now every aspect of research needs approval, including large audits, extraction of anonymised data, and even questionnaire based research. This applies to the low level interesting research that changes day to day practice. The ethical approval process is endlessly bureaucratic and opaque and is subject to constant delays and redrafts. Many simply give up or never start. Only those with commercial interest and organised special interests groups are motivated enough to continue. The outcome of no research is no evidence, biasing the evidence base ever further. We need radical reform of the ethical research approval process because we need some new, simple, and wholesome ingredients in our medical recipes.

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