ETHICS MAN **Daniel K Sokol**

Who wants to be the flu doctor?

No system for choosing a general practice's lead on pandemic flu is likely to be without problems

In 1841 the *William Brown* struck an iceberg in the North Atlantic. The doomed ship sank with 31 passengers. The remaining passengers scrambled onto lifeboats. In one of the lifeboats the escapees were so heavy that the first mate feared the boat would sink. He instructed his eight crewmen to "go to work, or we shall all perish." Sixteen passengers were thrown overboard.

Last month some general practitioners contacted a clinical ethics committee. They cited official guidance: "Every GP practice must identify the person in the practice who will act as the practice lead on flu pandemic issues." The flu lead may have greater exposure to flu patients than colleagues. Perhaps unsurprisingly, none of the GPs wanted the job. The question, admittedly oversimplified, was: who should they throw out of the boat to be the flu lead?

The guidance did not specify how the lead should be selected, and anecdotal reports suggest that general practices vary in how they appoint the flu lead and select those doctors who undertake more flu work than others. I recently met one GP who was told she would do the bulk of home visits to patients with suspected flu because she had no children. Another "flu lead" I met was chosen because she lived within walking distance of the practice.

The optimal way to resolve the problem is to seek volunteers. By reassuring the staff of the relatively small risk and reminding them of the training offered, their duty of care, and the benefits to patients, it may be possible to persuade one member to assume the role of flu lead. To entice volunteers, the practice may offer incentives. For example, during the outbreaks in Toronto of severe acute respiratory syndrome some clinicians were offered "risk pay." Let us assume, however, that in spite of the reassurances and benefits, none of the GPs steps forward. What next? There are two main options, each unpalatable. Firstly, pressure someone to be the flu lead; secondly, ignore the guidance, which would disadvantage patients in the area, increase the risk and workload of colleagues elsewhere, and put the GPs at administrative risk.

In 1841 the first mate ordered the crew on the lifeboat "not to part man and wife, and not to throw over any women." It is doubtful that the second part of this gentlemanly principle would hold water in 2009. The first part raises the issue of competing duties or "mixed agency" (Howe E. Mixed agency in military medicine: ethical roles in conflict. In: Beam T, Sparacino L, eds. *Military medical ethics*. Vol 1. 2003;331-65). If a GP is married, he or she has responsibilities as a spouse. If the GP has children, he or she has responsibilities as a parent. These responsibilities can clash with the medical duty of care (recall the General Medical Council's dictum: "make the care of your patient your first concern"). Flu doctors run a risk of failing in their duties as spouse or parent. They may be quarantined or decide willingly to stay away from their loved ones when treating flu patients. Single, childless GPs, unburdened by such conflict of duties, may have a stronger moral obligation to volunteer.

In the real world, however, this is unhelpful. A GP might protest: "I've got just as strong a commitment to my long term partner" or "I've got a demented mother who needs me." How would we decide which competing duties are strongest? And, of course, people can invent bogus reasons that would be impractical or impossible to verify. Even if it were possible, there is no guarantee that the reluctant recruit would turn up to work when called upon. If one candidate is clearly better suited to the task than the others—for instance, he or she was an infectious disease specialist before becoming a GP—this would strengthen the individual's obligation to volunteer, although again this may be offset by other non-professional obligations.

If no substantive criteria for selection can be chosen, a procedural system should be adopted. The first mate's initial suggestion for choosing the victims was to cast lots, and this system, if a little crude in appearance, has the benefit of objectivity, equality, and practicality. In a critical care situation with insufficient beds or in a sinking, overpopulated boat, when time is of the essence and sentimentality perilous, a lottery system may be the best available method. It is also unlikely to create as much unrest in the practice as other methods that are based on matrimonial status, number of children, clinical experience, age of practitioner, and so on. The coercive element is reduced if the candidates consent to the selection process.

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Here I have outlined some thoughts on this emerging issue, but GPs should discuss among themselves the fairest way to select the flu lead and the matter of risk distribution. The team may agree to exonerate some high risk members from consideration, appoint more than one flu lead, or distribute the flu patients equally among members. If the volunteer option fails, some GPs might reject the lottery system, preferring another method.

It is doubtful that any system will be unproblematic. The volunteer may not be the best person for the job. The GP who draws the short straw may be pregnant, have frail parents, or be more immunologically susceptible to the disease than colleagues. Each option will have its advantages and disadvantages, respecting some moral values and ignoring others. In such difficult dilemmas justice asks for no more than a morally defensible and transparent process of decision making. As the maxim goes, justice must not only be done but be seen to be done.

Daniel K Sokol is lecturer in medical ethics and law, St George's, University of London
daniel.sokol@talk21.com

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THE FUTURE OF HEALTH CARE **Ara Darzi**

Why innovation matters today

If we want a world class health system, we must constantly question and challenge what we do

The buzz around innovation in health care has been steadily increasing over the past few years, and the first ever healthcare innovation expo held in London in June was an example of the passion that the subject inspires in a wide range of people, from NHS organisations to drug companies and from foreign governments to local charities. However, translating this enthusiasm into action can all too often prove elusive. In recent surveys 70% of executives said that innovation would be one of their top three drivers of growth for their organisation over the next five years, but at the same time 65% admitted that they were only somewhat, a little, or not at all confident about the decisions they made in trying to stimulate innovation.

Innovation in the NHS isn't just hype, though—the service has a tradition of innovation, stretching back across its 61 year history. Pioneers such as Peter Mansfield, who developed magnetic resonance imaging (MRI), and Cicely Saunders, who founded the first modern hospice, are just a couple of examples of those from this country who have made major contributions. However, despite this talent for invention, the NHS has long recognised that it needs to do much more to promote the adoption and diffusion of innovations; in Mansfield's case MRI had a far more rapid uptake in the United States than it did in the United Kingdom.

After my report *High Quality Care for All* was published last year a number of initiatives were launched to encourage greater uptake and application of innovation. All strategic health authorities are now under a legal duty to promote innovation, which is being supported through the introduction of a £220m (€250m; $360m) innovation fund and £20m for national innovation prizes, to stimulate research in areas of particular concern. The National Institute for Health and Clinical Excellence (NICE) has also launched NHS Evidence, an online portal that provides people working across health and social care with the world's best evidence and best practice at the touch of a button. This service had almost one million visitors in its first month alone.

The NHS ambition to put quality at the heart of everything it does relies on clinicians and staff at all levels of the service talking to each other and their patients about what quality looks like. Different solutions will emerge from places all over the system, but all of them will rely on a willingness to embrace innovation. Besides leading to a higher quality of service, this innovation will also lead to greater productivity in our existing resources—this will be essential as the whole country continues to cope with the effects of the recession.

A recent book on "disruptive innovation" proposes that we consider today's challenges in health care in a radical and compelling new light. The authors argue that medicine continues to move dramatically from an intuitive level to an empirical (and eventually precise) one and that this causes tensions in healthcare systems that are still largely based on an intuitive diagnostic model, from GPs through to acute care. I believe this is the kind of bold thinking that the NHS needs to embrace if it is, through innovation, going to provide for our population's healthcare needs in the 21th century.

Innovation in the NHS isn't just a luxury: it's a necessity if we want to have a health service that provides high quality care for patients' ever evolving needs. In a recession there is a particular danger that focus on innovation can be lost, which would be damaging not just for the progress already made in the NHS but also for its long term future.

Three areas are of particular concern. Firstly, we may no longer make innovation a priority in our workforce and lose talent, instead resorting to a command and control mentality that stifles new thinking. Secondly, we may cut back on technology and stop new product development, resulting in patients not being able to get the most effective and efficient treatments. And lastly, we may reduce our appetite for risk and collaboration, both vital ingredients for a healthy and innovative organisation.

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If we want a world class healthcare system we need to dedicate ourselves to constantly questioning and challenging what we do. This means being open to innovation and recognising that the practices and attitudes of the past 60 years are not necessarily appropriate for the patients of tomorrow. Innovation in health care is about much more than research and development, new drugs, and shiny kit: it is about challenging ourselves to invent and adopt new ways of thinking. I know from my own experience that we will not realise our ambitions if we simply do the minimum asked of us. Many staff and clinicians already put in extra effort because they care about the quality of the service they provide, and thousands of individuals in the NHS have an insatiable appetite to make things better. Innovation means not just doing something new but doing it better.

Ara Darzi is professor of surgery, Imperial College London
a.darzi@imperial.ac.uk

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