

VIEWS & REVIEWS

REVIEWS OF THE WEEK

The luck of the draw

New Labour came to power promising to do away with the postcode lottery in health care, but inequity is still rife. **Ike Iheanacho** is impressed by a documentary that illustrated just how nonsensical things have become

Panorama: The NHS Postcode Lottery—It Could be You

BBC One, Monday 18 August 2008, 8 30 pm

Rating: ★★★✧

“If you are ill or injured there will be a national health service there to help; and access to it will be based on need and need alone—not on your ability to pay, or on who your GP happens to be or on where you live.”

Ultimately, promises are all that an aspiring party of democratic government can really offer. However well intentioned, such aspirations can easily be dismissed by a sceptical electorate as cheap talk. To be seen as anything more substantial, they must somehow home in on the weaknesses of those in power, encapsulate the public's disaffection, and suggest a better future.

The above pledge, made by New Labour in 1997, ticked all these boxes. In particular, the proposed eradication of postcode

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prescribing chimed with UK society's perceptions of fair play and the perceived role of the NHS. And there's no doubt about the time and effort that have since been devoted to addressing the central

issue of treatment that is based on affordable clinical need, especially through the creation of the National Institute for Health and Clinical Excellence (NICE).

The trouble is that, 11 years and three elections on, the postcode lottery remains a thriving, unregulated business. Some would even say that its continuing existence makes a mockery of references to a “national” health service.

That was the argument of *The NHS*

Postcode Lottery. This half hour, sniper's bullet of a programme targeted inconsistencies in funding of new drugs in different parts of England and between the UK countries. It highlighted cases of patients without access to particular treatments, because of funding decisions by their local primary care trust (PCT)—judgments starkly at odds with those in other areas. This was a good story, well told, but not groundbreaking investigative journalism. It cannot have been too difficult to find patients and consultants willing to point out flaws in the current arrangements. Nevertheless, the documentary distinguished itself by illustrating just how nonsensical things have become.

For example, we heard how one ophthalmic surgeon had three distinct approaches to management, determined by whether or how the patient's PCT funded drug treatment for wet age related macular degeneration. The luckiest people have access to the licensed drug ranibizumab (Lucentis); others can only have bevacizumab (Avastin), a cheaper treatment but one that is under-researched and unlicensed for macular degeneration. Outright losers in the lottery get neither treatment. A more damning demonstration of inequity would be hard to think of.

Hovering in the background to this mess are NICE and its guidance on specific interventions. The programme seemed keen to implicate NICE in the variability in funding, citing, for instance, how the protracted (and as yet uncompleted) process of producing definitive guidance on ranibizumab has put patients entirely at the mercy of PCTs' decisions on whether to fund provision of the drug.

But as the programme also showed, marked variation in treatment availability can still result even where clear national guidance exists. A key example is the



NICE chief executive Andrew Dillon gave a quietly robust defence of his organisation and its advice

fallout from NICE's recommendation against bevacizumab for advanced bowel cancer, meaning that patients can receive the drug only through discretionary exceptional funding, a position that actively promotes local variation, given the lack of standardised criteria for defining exceptional circumstances. Nor can NICE be held responsible for the rules dictating that patients who want to pay for expensive drugs they would not otherwise receive have to take on the financial burden of other aspects of their care too—a perverse position currently under review at the behest of the Westminster and Edinburgh governments.

And at least Andrew Dillon, NICE's chief executive, was prepared to be interviewed on camera, giving a quietly robust defence of his organisation and its advice. It would have been good, too, to hear much more from decision makers at PCT level. One medical director tried to explain why his PCT had turned down most requests for exceptional funding. However, as the PCT had been criticised for weakness in managing its resources by the Healthcare Commission, he was not the best placed to make his points. Hearing from PCTs without such baggage could have injected useful balance.

Other potential witnesses were conspicuous by their absence. The programme makers had sought an interview with the Department of Health on how it proposed to realise the Westminster health secretary's recent commitments on fairer access to drugs. That their request was turned down spoke volumes. Promises, promises. Ike Iheanacho is editor, *Drug and Therapeutics Bulletin* iiheanacho@bmjgroup.com

Cite this as: *BMJ* 2008;337:a1366

Des Spence on
revalidation,
p 464



The men of steel

The question of whether technology can ever replace doctors kicks off an excellent new series by Robert Winston, writes **James Owen Drife**

SuperDoctors

BBC One, Thursdays, 9 pm

Rating: ★★★★★

This has been a big week for medicine on terrestrial television in Britain. On Sunday Channel 4 gave us vulval cosmetic surgery. On Monday *Panorama* investigated the NHS postcode lottery (see Review, opposite page), and on Wednesday BBC Four began *Blood and Guts*, a series about the history of surgery. On Thursday Robert Winston presented *SuperDoctors*.

The working title of this series was *Medical Frontiers*, but after *The Perfect Vagina* and *Blood and Guts* that would have seemed dull. Indeed, running the words “super” and “doctors” together raised hopes that we might see colleagues wearing red capes and operating with kryptonite scalpels.

Mercifully, the programmes are much better than their dumbed down name. They take a hard look at the problems of introducing new technology in medicine, surgery, and—we’re promised—physiotherapy. Inevitably, perhaps, surgery was first, preceded in *Radio Times* by a gee-whiz article (headed “Robodoc”) about a Canadian neurosurgeon removing a tumour by remote control.

The tone of the programme itself, however, was sceptical. Winston did not patronise viewers. He used to be a laparoscopic surgeon and began by voicing his doubts about the value of expensive technology that comes between doctor and patient. Then, through three illustrative cases, he explored the pros and cons of surgical innovation.

Case one began with a coup de théâtre. A robot, like something from *Star Wars*, trundled into a ward, and on its screen was the face of

Ara Darzi, who apparently combines the job of minimal access surgeon with his other role as health minister in charge of reforming the NHS in England. He and Robert Winston are both professors at London’s Imperial College and members of the House of Lords. We viewers leaned forward, expecting sport, and were not disappointed.

The first patient, an elderly Irish woman, told the robot that she was recovering well from her operation. Winston solemnly assured

“I just feel that robotic doctors are completely contrary to what medicine is about,” says Robert Winston



the viewers that for such a hugely busy man as Lord Darzi (a few kilometres away) this technology, costing the equivalent of two junior doctors’ salaries, was economic. As the noble dalek disappeared the patient murmured, “That was worse than the operation.” Spontaneously, Winston crouched down and asked her, “What was it like, talking to a robot?” She chuckled. “Like talking to my husband—he’s going a bit deaf.”

One of Winston’s strengths is an ability to convey genuine warmth at such moments. Another is forthrightness: “I just feel that robotic doctors are completely contrary to what medicine is about.” Yet another, particularly relevant to this programme, is that he is at home in an operating theatre. To my surprise the theatre in case two turned out to be in Leeds, where I work. What a way to discover what your friends are up to.

I learnt that one of my paediatric colleagues is a pioneer of laparoscopic surgery with the Da Vinci robot. The programme was going to show him using it for only the seventh time, and on his smallest ever patient. The baby was the son of a doctor, who explained that he and his wife had consented to the procedure because they had complete trust in the

surgeon. Quite a burden, said Winston in the corridor, before telling us about his own colleague who used to anaesthetise Winston’s gynaecological patients for laparoscopic microsurgery. That anaesthetist, we learned, had chronic indigestion and chose to undergo laparoscopic surgery himself but did not survive the operation. Winston said that after he heard this he stopped operating.

Back in theatre he asked the surgeon and anaesthetist about the risks to the baby. Their frank, businesslike replies came across well. Winston interpreted the operation for us and struck just the right note—at least for me, watching a preview DVD over breakfast, spellbound with a jar of marmalade in my hand. More telling than the excellent script and memorable unrehearsed remarks was the eloquent camera work—a nurse quietly cuddling the baby, or the surgeon’s car leaving in the dark.

For the third case, in Calgary, Alberta, Winston tried out a stupendously expensive robot in a virtual environment before watching it being used to help remove a brainstem tumour. Later we saw the Leeds baby thriving and the Canadian patient looking more facially asymmetrical than before surgery (but convinced he would improve). Contrary to the hype, Winston’s conclusion was that, compared with human skill, the role of robots is minor and maybe unnecessary.

The message of this series is that risk taking is needed to advance knowledge but that these risks must be managed. Next week’s programme looks at stem cell therapy, comparing a patient who undergoes it as a last ditch treatment with one who volunteers for a double blind trial. We are being painlessly educated here, but what really shines from these programmes is the importance of empathy. They say more about doctor-patient partnerships than a shedload of official guidance.

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Cite this as: *BMJ* 2008;337:a1363

A review of *Blood and Guts* is available on bmj.com and will appear in the next print issue of the *BMJ*

The revalidation question

FROM THE
FRONTLINE
Des Spence



It was 1995, and I had smoothed down my hair, flattened my John Major suit, and adjusted my silk tie—this was my viva examination for membership of the royal college. This was a time of Russian roulette examinations, and everything depended on the examiners. My goal was to be just like them, such is the power of peer pressure. A hot question then, as now, was revalidation, and I had my response learnt, though without the pain of experience.

The ideas behind revalidation seem like common sense: ensuring quality and protecting patients from the mistakes of the past. The question is not whether but how these aims are to be achieved. Much has already changed in the past decade; the professional scars of Bristol, Alder Hey, and Shipman are deep and still tender. The new mantra is, quite rightly, to protect patients above all else. And this new generation of doctors is increasingly literate in communication skills and medical ethics. So any new plans for revalidation must not be a belated over-reaction to the mistakes of the past. They should acknowledge that our profession is multicultural and diverse, requiring doctors with a range of attitudes and skills, and not impose a clumsy photofit caricature of what we should be.

The greatest concern, however, is the call for yet more involvement of the public. Clearly we need to respond to patients, but involving the public is already fraught

with difficulties. Firstly, vociferous special interest groups who ignore the views of the silent contented majority may distort the public voice, skewing care. Secondly, biased “patient satisfaction” feedback (which is often anonymous and not validated) has become the single yardstick of quality of care. Regrettably, this feedback focuses almost exclusively on the negative and is already destroying NHS morale. Anyway, sometimes denying patients “what they want” is a fundamental professional duty of care (so long as it is properly explained). Distant government quangos should appreciate that doctors are not selling toasters and that the customer is not always right. The pursuit of consumerist health care is the single greatest threat to our society’s wellbeing.

Lastly, the medical authorities already know which doctors are failing and that resources should be targeted at supporting these doctors. Revalidation has to be a realistic process, and we should accept that it will not prevent the determinedly deceitful doctor. Revalidation must be simple, be based on knowledge, use statements of support from peers, and, above all be free of fickle political interference. If not, practising medicine won’t just be difficult but nigh on impossible.

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Cite this as: *BMJ* 2008;337:a1353

There is nothing like the real thing

THE BIGGER
PICTURE
Mary E Black



I have been involved in competitive sailing for years. Equipment, tactics, team psychology, logistics, nutrition, medical support—I can discuss all these and give you my measured and informed opinion. Give me a team trip to organise or a race strategy to review and I can throw my weight around. For I have seen it all either from the harbour, through my binoculars, or up close from a judge’s boat. But this week was the first time I had competed. And nothing had prepared me for the real thing: the adrenaline rush and naked aggression of the starting line, the constant loud noise of flapping sails, getting hit on the head with a flying boom, the thrill of winning. It also came as a shock to be valued mainly for my contribution as obedient, non-verbal ballast and minor rope tweeker.

In medicine you can analyse problem based learning cases, suture artificial skin, even do brain

surgery via computer simulation. But the day you get your hands dirty is when you put all that theory into practice. Nothing can quite prepare you for the sticky consistency of blood, the smell of singeing bone as the drill cuts through, the despair of grieving parents, the irritation caused by difficult colleagues, or the sickening awareness of your first big mistake. And no simulation can recreate the satisfaction of a five hour operation when that last line of sutures goes in, being in an effective resuscitation team, or enabling a terminally ill man to stay at home with his beloved wife supported by home nursing.

Audits and management reviews are necessary and useful. But they are as far from the dirty, tough, exhilarating, fantastic, rewarding reality of teamwork health care as I was from competitive sailing when sitting there on the sidelines with my binoculars. The best managers are

aware of this; the worst throw their weight around without thinking or without understanding how teams work. For in medicine, as in sailing, frontline experience counts.

Tomorrow I will pull on my gloves and get on that boat again. I will admire the competence of my 11 year old as he helms, respect my husband as he hauls the heavy mainsail, and applaud my 13 year old as she scrambles around the rigging. I will listen carefully, keep my opinions to myself (at least till after the race), distribute my (literal) weight around with care, and do everything I can to help the team reach our goal: to get us all safely round the course and to win. My knees will be bashed, my ego squelched, and my sailing management skills improved. Reality really is the best teacher.

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Cite this as: *BMJ* 2008;337:a1346

Too posh to infect?

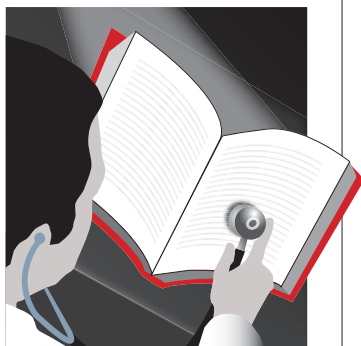
In John Buchan's last book, *Sick Heart River*, published posthumously in 1941, the protagonist, Sir Edward Leithen, has been given a year to live by an eminent London specialist, Acton Croke. A gas attack in the first world war has awakened tuberculosis as a delayed effect, and it is now galloping through his lungs. Although occurring only a handful of years before the discovery of streptomycin, Sir Edward's tuberculosis is a death sentence.

Buchan finished the book just a few days before his own death from cerebral thrombosis. Then governor general of Canada, he had been a martyr to peptic ulcer for decades, and he eked out his bland poached eggs at elaborate state dinners while everyone around him gorged themselves.

When the first papers were published suggesting that peptic ulcer was, in effect, an infectious disease, and that a poached egg diet was all in vain, I read them with incredulity. Surely, I thought, this is all too simple? At the time, I was practising in a far distant land where tuberculosis was by far the most common disease: so common, indeed, that everything was considered tuberculosis until proved otherwise.

By then, of course, a variety of anti-tuberculous drugs were available, so few people died as Sir Edward does in the book. The book has a wonderful description of what it is like to fight for breath, something that I saw in the worst cases: "His difficult breathing became almost suffocation. The business of filling the lungs with air, to a healthy man an unconscious function, had become for him a desperate enterprise where every moment brought the terror of failure. He felt every part of

BETWEEN THE LINES Theodore Dalrymple



Was it that, in those days, certain people were so socially prominent that doctors did not dare suggest to them so vulgar a matter as contagiousness?

his decrepit frame involved, not lungs and larynx only, but every muscle from his brain to his feet."

Having received his sentence of death from the appropriately named Croke, Sir Edward, a successful lawyer and politician, decides to die on active service. He embarks on a voyage in search of the good death, and the meaning of life, in the freezing far north of Canada (where Buchan himself had travelled as governor general in 1937). The pretext for his journey is the search for a successful New York financier called Galliard, French Canadian by origin, who feels the call of the wild and disappears from New York, where he has led what he believes to be an artificial life. Galliard goes in search of the mythical Sick Heart River, whither Sir Edward follows him and where he thinks he will find content.

Did Buchan have in mind, I wonder, these lines from Hamlet? "For this relief much thanks./'Tis bitter cold,/And I am sick at heart."

One thing worried me about the account of Sir Edward's disease. I could not at first put my finger on what it was. Then I realised: presumably his tuberculosis was of the open variety, yet Acton Croke, the Harley Street specialist, never mentioned the danger of spreading it to others or showed any interest in that possibility.

Was it that, in those days, certain people were so socially prominent that doctors did not dare suggest to them so vulgar a matter as contagiousness? Or was the omission mere poetic licence on Buchan's part?

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Cite this as: *BMJ* 2008;337:a1354

MEDICAL CLASSICS

The Doctor and the Devils

By Dylan Thomas First published 1953

This poetic screenplay from the 1950s raises questions, still pertinent today, about the pursuit of medical knowledge. Informed by the story of the body snatchers Burke and Hare, it tells of Dr Rock, a bright and ambitious anatomist who needs bodies to dissect. These come to be supplied, increasingly fresh, by the two characters Fallon and Broom.

A charismatic and contradictory man, Rock has a mind of his own. He is contemptuous of the "false pride and prejudice" that maintain sharp class divisions, believes passionately in his work, and has a following of young, rather awestruck students. For him the purpose of medical study is "the pursuit of the knowledge of man in his entirety"—that is, as a physical, moral, emotional, and social being. He believes that the pursuit of knowledge is an end that "justifies any means . . . Let no scruples stand in the way of the progress of medical science!" As the plot unfolds, the degradation of moral character caused by "the devil" greed, whether for money and food in the case of Fallon and Broom, or knowledge and glory in Rock's, is revealed.

Fallon and Broom gradually progress from grave digging to murdering. Their women go along with this but are troubled in a way that mirrors the disquiet of Rock's colleagues who receive the fresh corpses. Rock refuses to be concerned about this trade, the problem to his mind being the law that stands in the way of a legitimate supply of bodies for dissection. He denigrates the Resurrectionists (as the body snatchers are known) and sees himself as above the law; it is this superior sense of himself that is his downfall. As the murdering is being discovered, Rock is speaking: "Let us today dissect the human conscience . . . the conscience is a very unhealthy subject." He becomes increasingly entrenched: "Mine is the right direction. The fact that the majority

would consider it the *wrong* direction only substantiates my opinion that I am right." The crimes come to light when outsiders stumble on Fallon and Broom's activities and contact the police.

Dylan Thomas captures the jealousy and envy engendered by the "clever monkey" Rock as well as the saner concerns about his activities. The struggle of "disregarding personal prejudice" probably contributes to the delay in attending to what is going seriously wrong. In addition, conservative self interest means that senior establishment figures successfully resist the wish of the police to try Rock, because "the whole aristocracy of learning that has been so carefully built up would be tumbled to the ground. The stain upon his character would spread across the whole of our culture. There could be no more respect for us. Indictment of Rock would mean the death of a class."

Rock is, however, fiercely hounded by "the mob." He is aware that he will hear "the voices of the crowd . . . inside my head" long after they have forgotten him. The script ends with his cry, "Oh, my God, I knew what I was doing!"

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Cite this as: *BMJ* 2008;337:a1373

