



**“If doctors and nurses don’t seize this opportunity to reform NHS productivity, then the government will be seduced by the private sector”**

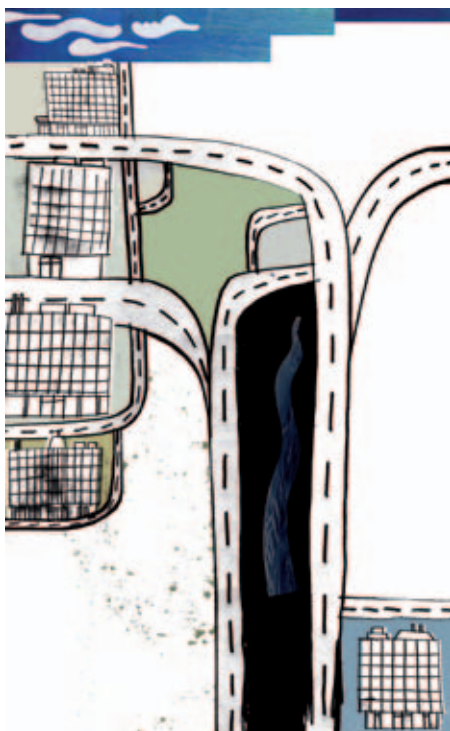
Des Spence on Twitter, p 1275

PERSONAL VIEW **James A Smallwood**

# We must reconfigure healthcare providers

The time has come to tackle the configuration of healthcare providers in the NHS. Do we need the current number and disposition of hospitals to meet the population’s health needs, evidence based practice and quality targets? Can we afford to sustain so many small independent general practices from the public purse? Are providers fit for purpose, and are they working well together in the interests of patients? Has the piecemeal introduction of competition produced high quality, cost effective care?

In my health economy, serving a population of about two million people, there are seven acute hospitals and two large community hospitals within a fifty mile radius, with two acute hospitals only twelve miles apart. In two modest sized local rural towns, there are three independent general practices with extensive premises within a five minute walk of each other. Current provider configurations, it seems, have often grown randomly, without long term vision. Yet explicit proposals for modification are frequently halted by the mistrustful responses in public consultations, resulting in weak political decision making.



ROB WHITE

The only solution must be a blueprint for provider reconfiguration that encompasses all parties and looks to the needs of the population over the long term. This can be easily guided by neutral drivers, such as patient pathways, best practice guidelines, and the principles that have governed highly successful national service frameworks (cancer and cardiac networks, for example). Reconfiguration must engage the intelligence and imagination of local populations instead of the fear of closure or reduction in capacity that usually arises in response to plans for reform.

Some configurations, because of evidence of benefit, may reduce the number of hospitals offering highly specialist centres. This is happening to some extent already with the major trauma centres, vascular networks, and paediatric intensive care units and surgery. There is evidence that people are willing to travel to specialist centres where this is indicated (<http://bit.ly/s8DCZ6>). People are less interested in an offer of choice irrespective of benefit and certainly not to serve the interests of competition.

It is surprising that successive governments have not planned greater reform in the primary care sector. The number of, and the variation in quality of care of, general practices is now a focus of the Care Quality Commission. It makes sense to have fewer and larger practices that can, by virtue of size, run economically viable diagnostic and therapeutic services and robust out of hours services, effectively reducing unnecessary hospital admissions and getting people out of hospital more quickly (as recommended by the Department of Health’s *Our NHS our future: NHS next stage review*—<http://bit.ly/vwtAEC>). Such polyclinics would integrate patient pathways under one roof, with collaboration between primary and secondary care. The mergers required could easily form part of the Care Quality Commission registration process now being encouraged for governance and patient safety.

The role of the private sector can only be judged after the provider structure has been

substantially rationalised. The role of current independent treatment centres, with their generous up front contracts, now under considerable press scrutiny, needs to be reviewed. Indeed, with a less attractive national or competitive tariff their role in driving down cost through competition may become redundant. It must also be time to overhaul the private finance initiative contracts that robust analyses have shown to be unaffordable and in many

instances paralysing to local health economies, such as in Portsmouth, Norfolk and Norwich Hospitals, and Barts and the London NHS Trust (*BMJ* 2011;342:d324).

It has been the habit of politicians to seek answers from overseas; usually across the Atlantic where there is still an

unacceptable inequity of care and lack of cost efficiency. Where the private sector can work well it should be integrated in line with and in the context of our system; not at the expense of destabilising the core NHS and its commitments to training, research, and development.

As a career NHS medic with managerial experience I am aware of how ever more complex the NHS has become in all its structures and functions and the massive effort that is required to make it work. Aiming guns at those who are charged with managing such complexity is absurd. It must be made simpler.

There is in my view a genuine need, irrespective of the bleak financial outlook, for a review of the whole system, which must start with the rationalisation of providers, not yet more changes to the type of commissioner. Asserting political will is one thing, true leadership to maintain the NHS as a vital social and economic asset will rely on delivering functional political partnership. Collaboration at a political level to identify the solution as well as the problem could sweeten the pill of NHS reorganisation, even in the current economic reality. Will politicians be able to deliver?

James A Smallwood is a surgical oncologist, Department of Surgery, University Hospital, Southampton SO16 6UY [jamesasmallwood@gmail.com](mailto:jamesasmallwood@gmail.com)

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A friend told me this week that she had cancer. What did I do? I cried. After she left I felt foolish. Had I been wrong to cry? From a clinical perspective, yes; as a friend and mother with children of a similar age, no. Before she told me, I felt that I knew what my friend was about to say, but I didn't want to believe it. The idea of humour in this situation was inconceivable, yet it is through humour that the screenwriter Will Reiser has chosen to retell his own story of surviving cancer in the film *50/50*.

Adam, 27, is diagnosed as having a rare, malignant spinal tumour. We follow his journey through diagnosis and treatment, with his best friend Kyle at his side. He is given a 50/50 chance of survival; hence the title of the film. The focus is the characters' relationships and how they evolve in response to this life redefining challenge. Films about cancer are usually tear jerkers and often depressing tales; examples such as *Wit* (2001) and *Love Story* (1970) come to mind. But this film is different because it successfully finds humour in the darkest, most unexpected moments—something that medics have long been known to use as a coping mechanism. Although *50/50* is based on Reiser's personal experience, there are occasional Hollywood moments. For example, Adam goes clubbing, something most patients undergoing chemotherapy would not be capable of.

*50/50* takes the medical profession back at least a decade in terms of communication with people, and it mocks the way communication skills are now taught at medical school. The scene in which a doctor discloses the diagnosis is stereotypical; the doctor objectifies the condition without considering the patient's comprehension, the personal significance, and emotional response. Adam sees Katherine, a doctoral psychology student, to help him come to terms with his diagnosis, and she breaks many professional boundaries and



## REVIEW OF THE WEEK

# Laughter in the dark

A comedy film about rare cancer has saving graces, despite its vision of the medical profession, says **Priya V Joshi**

ultimately becomes a love interest. Katherine's behaviour is portrayed in a positive light, however, rather than highly unethical.

When Adam meets other people with cancer who are undergoing chemotherapy, they introduce themselves by their name, rapidly followed by their diagnosis. Feeling defined by a cancer is a problem that websites such as [www.mynamemiscancer.com](http://www.mynamemiscancer.com) aim to help people overcome. The film humorously depicts Adam using his hairless head and cancer diagnosis to evoke sympathy from attractive women, for personal gain—that is, sex.

A 27 year old man without risk factors developing cancer makes for uncomfortable viewing, and *50/50* shatters the illusion that you can't get cancer if you don't smoke or drink. Although the film reflects the reality that cancer is

indiscriminate (many young people see it as a disease exclusive to older age), *50/50* perhaps goes too far in presenting the fatalistic view that healthy living is futile. On the other hand, modifiable risk factors in cancer exist, but patients are easily confused, or worse: they become indifferent. One recent study, although not reaching statistical significance, shows that although obesity is a well known risk factor for colorectal cancer, only 32% of obese or overweight participants identified obesity as a risk factor, and 57% said that their own body mass index did not represent an increased risk (*J Cancer Educ* 2011;26:767-73). Similarly, a study in *Thorax*, which looked at attitudes to participation in a lung cancer screening trial, found that patients who smoked but declined to participate in the screening programme rationalised

**This film successfully finds humour in the darkest, most unexpected moments—something that medics have long been known to use as a coping mechanism**

## 50/50

A film directed by Jonathan Levine; written by Will Reiser

On general release in the UK

[www.50-50themovie.com](http://www.50-50themovie.com)

Rating: ★★☆☆

their decision by underplaying the risk and had the perception that negative family history and good health were protective (*Thorax* 2011, doi:10.1136/thoraxjnl-2011-200055).

*50/50* has the potential to educate. The film reminds medical professionals to consider cancers that are seldom encountered, something referred to in the recent Department of Health report *Improving Outcomes: A Strategy in Cancer* (<http://bit.ly/gMTbjn>). The report is informed by work by the Rarer Cancers Foundation ([www.rarercancers.org](http://www.rarercancers.org)). The foundation's audit of patients' experiences of primary care found that of 322 patients, 71% had not been asked about a family history of cancer; more than half of patients said that they had visited their general practitioner more than twice before receiving a correct diagnosis; and almost a third of patients were reassured and not asked to return for review (<http://bit.ly/sFSV89>). Increased awareness has the potential to enable diagnosis before cancer reaches advanced stage, with prognostic implications.

The audit also found more than 40% of people don't see a doctor for three months after getting symptoms, and for these people the film shows how indiscriminately affliction occurs, prompting assessment of personal risk.

*50/50* ends with Adam recovering from his surgery and dating his therapist Katherine, happy ever after, in true Hollywood style. Reiser has now been in remission for six years. Here is a story about cancer survival laced with wit and gallows humour; a refreshing change to more pessimistic predecessors.

Priya V Joshi is core medical trainee, St Mary's Hospital, Imperial College Healthcare NHS Trust, London W2 1NY [priyavjoshi@doctors.org.uk](mailto:priyavjoshi@doctors.org.uk)

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BETWEEN THE LINES Theodore Dalrymple

# Snobbery with violence

Two whole generations, I suppose, may now have grown up without any knowledge of hat pins, not even that they once existed. I was raised just as they were disappearing along with the hats that they kept attached to ladies' heads. My grandmother's hat pin fascinated me almost as much as her smell of mothballs, and her fox fur stole that ended in fox heads with beady glass eyes. Her hat pin was by far the largest pin that I had ever seen, and had a sphere of jet at its end (all her hats were black). Even at the age of eight, I saw it as a potentially lethal weapon, and wondered what would happen if you stuck such a pin through someone's chest. Would it reach the heart?

A hat pin plays an important part in the story "The Archduke's Tea," in the collection of stories *Call Mr Fortune* published in 1933. Reggie Fortune, MA, MB, BCH, FRCS, is the detective hero, "a specialist in the surgery of crime." He was devised by H C Bailey, whose day job, as it were, was leader writer for the *Daily Telegraph*. I first heard of H C Bailey and Reggie Fortune when I read Colin Watson's history of British detective fiction, *Snobbery with Violence*.

Reggie "was of round and cheerful countenance and a perpetual appetite." He is so neat that "neither his hair nor anything else of his was ever ruffled." In general, he disapproves of expressions of emotion, even in the most stressful circumstances, as for example when a maid finds the body of a murder victim. He is ostentatiously cynical, on one occasion telling a policeman that he doesn't like his patients to be murdered, as only he has the licence to kill them.

It cannot be said that Bailey was a strict practitioner of social realism. In "The Archduke's Tea" Reggie Fortune has taken over his father's general practice in a prosperous suburb of London where, as it happens, Archduke Maurice of Bohemia is residing with Archduchess Ianthé. The archduke is the heir to the throne of Bohemia, but the archduchess does not

**He is ostentatiously cynical, on one occasion telling a policeman that he doesn't like his patients to be murdered, as only he has the licence to kill them**



Bailey: wrote of the surgery of crime

like being royal, hence their residence in suburban London.

Archduke Leopold, Maurice's brother and next in line to the throne, arrives, and shortly thereafter Maurice is knocked down by a car and run over. Who has done it? The archduchess, as it happens, is a motoring enthusiast, and their marriage is none too sound because Maurice has decided to return to Bohemia.

Reggie Fortune is called to attend to the unconscious archduke. He prepares an injection of strychnine to revive him in the presence of Leopold, and then leaves the strychnine in Leopold's presence. Leopold puts it in Reggie's tea, but Reggie deftly switches the cups; Archduke Leopold drinks the strychnine and falls dead, after a few requisite convulsions, at Reggie's feet.

There is no doubt that Archduke Leopold, who wants to accede to the throne, is a bit of a rotter. Among other things, he stuck his brother with a hat pin, after first running him over, in order to cast further suspicion on the archduchess; hat pins obviously being a woman's weapon. But whether Reggie's action in allowing Leopold to drink the poison is quite in accordance with the fundamental principle of medical ethics—first do no harm—may be doubted.

Reggie therefore has something in common with the relatives of *Pygmalion's* Eliza Doolittle, their very different social class notwithstanding, who, according to her, were prepared to do her in for a hat pin...

Theodore Dalrymple is a writer and retired doctor

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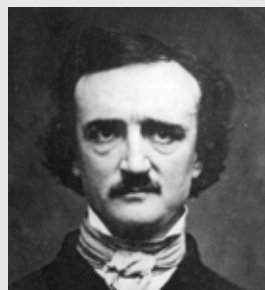
## MEDICAL CLASSICS

### The System of Dr Tarr and Professor Fether

A short story by Edgar Allan Poe; first published 1845

The 19th century madhouse was often portrayed as a place of pure gothic horror. What more natural subject, then, for that early doyen of the genre Edgar Allan Poe, so many of whose characters seem manic, morbid, obsessive, or just downright strange? Poe's short story "The System of Dr Tarr and Professor Fether" recounts a visit by an unnamed narrator travelling in France to a "maison de santé" or private madhouse. This is run according to the so called soothing system, where punishments are avoided and patients are "permitted to roam about the house and grounds in the ordinary apparel of persons in right mind."

Such regimes—and the very nature of insanity—had become topics of popular debate by the middle of the 19th century. So called moral treatment of mentally ill people had been devised by Philippe Pinel in France during the 1790s. The method was practised in Britain most famously at the York Retreat, and in the US at asylums in Boston, Philadelphia, New York, and elsewhere (all cities in which Poe had lived), but it was still novel. In 1843, for instance, the social reformer Dorothea Dix reported on the scandalous treatment of the insane poor in Massachusetts, who were shackled and beaten. Insanity pleas were increasingly common in criminal cases, prompting attempts to define what was mad and what merely bad—a task to which psychiatrists laid special claim. The year Poe wrote this story saw the foundation of the Association of Medical Superintendents of American Institutions for the Insane and the first publication of the *American Journal of Insanity*.



Poe: insane nature

Poe's narrator is invited to dinner by the asylum superintendent. At the dinner he naively attributes the eccentric behaviour of his fellow guests to their provincial ways. But the conversation and entertainment become progressively more bizarre until the room is invaded by what the narrator takes to be "Chimpanzees, Ourang-Outangs [sic], or big black baboons of

the Cape of Good Hope." They are in fact the real asylum staff, who have been tarred and feathered and locked up by the patients; the patients themselves have been masquerading as the dinner guests. The superintendent proves to have succumbed to madness some years before and become a patient in his own asylum.

The story resists easy interpretation. Is Poe ridiculing humane treatment of the mentally ill, or rather the pretensions of newly professionalised psychiatrists? No evidence suggests he ever underwent psychiatric treatment himself, although during a life of hardship and disappointment he endured periodic depression, attempted suicide, and drank heavily.

A letter in which Poe pondered the nature of insanity perhaps provides a clue: "Men have called me mad; but the question is not yet settled, whether madness is or is not the loftiest intelligence—whether much that is glorious—whether all that is profound—does not spring from disease of thought—from moods of mind exalted at the expense of the general intellect."

Peter Davies, freelance journalist, London [petergdavies@ntlworld.com](mailto:petergdavies@ntlworld.com)

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FROM THE FRONTLINE **Des Spence**

## All a-Twitter

Last week a storm battered Glasgow, and this was posted on Twitter: “Edinburgh, you can take our wheelie bins but you can’t take our banter, Glasgow.” I am wary of social media because those with 1000 friends on Facebook are socially bankrupt. I fear they will be left with no real friends at all, just false avatars. Friendship is the most precious but rarest social commodity. I delayed using Twitter, but last week I started. Twitter is an amazing source of news and information and its brevity makes it very accessible. So on a house call, in my car, buffeted in the wind, I crashed a Twitter discussion on my iPhone.

Hosted by the King’s Fund under #nhsausterity, the tweets ruffled my electronic feathers. “It’s about managers supporting clinical staff to deliver workforce productivity and investing in the right training.” This is the familiar rhetoric and language of the past decade. And other tweets highlighted a core problem: “KPMG work for EU shows UK medics in upper quartile pay,



**Medical corporations will sell short term efficiency, but in the long term will increase costs, putting profit before care**

## Twitter

Follow Des Spence on Twitter @Bad4UMedicine

lower quartile productivity.” The reality is a rapid twofold increase in NHS funding over a decade, with a 45% increase in medical staff ([www.nhsconfed.org/OurWork/political-engagement/Pages/NHS-statistics.aspx](http://www.nhsconfed.org/OurWork/political-engagement/Pages/NHS-statistics.aspx)). The NHS is profligate, with a scattergun approach to spending, and is addicted to management mumbo jumbo and constant reorganisations, producing fractionated care and promoting restrictive working practices. We’re just mindlessly measuring the measurable, neglecting the immeasurable. So should NHS funding be protected while other public services are cut? And should doctors, with large final salary schemes pensions, really consider industrial action to protect these rights?

Cuts to the NHS are absolutely inevitable because we are in the midst of an economic hurricane. Increased productivity is our only saviour. “Adversity reveals genius; prosperity conceals it.” The time has come for major innovation. We need a move away from management

and a return to a professional lexicon of duty, caring, and sacrifice. It is not an obsession with structures that make systems function—only people. We need no more talk of so called instructional failure but a return of individual professional responsibility, local control, and accountability. We do need more doctors as leaders, but these must be practising clinicians. No more training, nor management consultants, just a drive for local pragmatic solutions. Some current medical and nursing managers should be redeployed back to frontline clinical care. If doctors and nurses don’t seize this opportunity to reform NHS productivity, then the government will be seduced by the private sector. Medical corporations will sell short term efficiency, but in the long term will increase costs, putting profit before care. Twitter is the tool to unlock the genius of innovation that lies within the staff of the NHS.

Des Spence is a general practitioner, Glasgow [destwo@yahoo.co.uk](mailto:destwo@yahoo.co.uk)

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IN AND OUT OF HOSPITAL **James Owen Drife**

## A Christmas lecture

In my first interview for an academic post they asked me why I wanted to be a university lecturer. I said something like, “Well, I like lecturing,” and quickly realised it was the wrong answer. Nobody trusts a smart alec, especially one who enjoys public speaking.

At least my reply was honest, though nowadays that may be hard to believe. Back in the 1970s all you needed for a talk was a set of multicoloured felt tip pens. You had fun preparing customised overheads and the audience had a good time watching you attempt to project them the right way up. You were in complete control of the visual aids and could decide whether the top, middle, or bottom of the isosceles trapezium should be in focus.

In those days the recipe for a good lecture was a prolonged power cut

and that has become more true as technology has moved on. Today there are microphones, but they are in front of the speaker and not to the rear, where he or she is usually facing. There is a computerised projection system but nobody knows how to switch it on. The climax of the meeting is the breathless arrival of the secretary who knows the password.

A gulf has opened between the generations. Medical students, facing a technical hitch during their presentation, simply frown, tap the laptop and sort it out. Lecturers of my age generate audience participation as we move the cursor slowly around searching for the icon for full screen, which is in a different place on each postgraduate centre’s system.

Like everyone else, speakers are now enmeshed in red tape. Weeks



**Back in the 1970s you had fun preparing customised overheads and the audience had a good time watching you attempt to project them the right way up**

beforehand we have to complete an online form giving our aim, our five learning objectives, an abstract of 200 words (they will be counted by computer), a brief biography (I write a new one each time), and a statement on whether we shall require medical assistance to reach the podium.

But in December the rules are suspended. Next week I’m giving a Christmas lecture and all I have to do is turn up. This loosening of the bureaucratic straitjacket is unnerving. What style should I choose—scientific, nostalgic, provocative, funny (best avoided), or motivational (too expensive)? Or do they just want me for my white beard? Anyway at Christmas, who’s listening?

James Owen Drife is emeritus professor of obstetrics and gynaecology, Leeds [J.O.Drife@leeds.ac.uk](mailto:J.O.Drife@leeds.ac.uk)

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