Commentary – Lord Darzi interview

A policy perspective

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(Quotations from Lord Darzi are in italics)

As Lord Darzi notes *London was never short of reviews*. There have been 25 such reviews starting with those of the House of Lords Select Committee on Metropolitan Hospitals between 1890 and 1893.^{1,2} Eight of the most recent were published in the 1990s, the most important of these being Turnberg.³ There have also been specific commentaries and recommendations in two major national reports – the Royal Commission on Medical Education in 1968⁴ and an important chapter in the Royal Commission on the National Health Service in 1979.⁵

Whilst we might not anticipate consensus over such a lengthy time period, recurrent concerns have been identified consistently across the years. For secondary care these have been the need:

- for more and better co-ordination
- for more and better planning (including shifting hospital resources out of central/inner London)
- to rationalise hospital provision (including the amalgamation of smaller hospitals and the closing of inefficient units)
- to rationalise medical education (including the amalgamation of medical schools)
- to rationalise fragmented and inadequately supported specialist and clinical research units
- to replace ageing buildings and equipment
- to improve access to secondary care.

For primary, community and continuing care there have been long-standing concerns expressed about the inadequacies of these services which have been seen as much less comprehensively developed than the same services in the rest of the country, with particular problems in some parts of the capital. Issues identified in more than one of the many reports have been:

- the limited development of health centres
- the high proportion of single-handed GPs
- limited and inadequate out of hours services
- a lack of support staff
- unsuitable premises
- the lack of co-ordination with secondary care.

Finally we can note that some of the most recent reports prior to that by Lord Darzi identified the same challenges facing health in London – *the ageing population ... long-term conditions ... (and) ... a population that is very mobile*.

In undertaking his analysis of London – deficiencies and needs, strengths, challenges and achievements – Lord Darzi's commentary is similar to that provided in the London chapter of the Royal Commission on the National Health Service. In considering remedies, Darzi's case for polyclinics updates and develops the views of the Commission.⁵ Indeed the concept of the polyclinic can be traced even further back, not only to the advocacy of health centres in the early years of the National Health Service (little implemented because of financial and political obstacles), but also to the Dawson Report⁶ to which Lord Darzi refers and upon which we have written already.⁷ A key recommendation from Lord Dawson was the creation of a series of neighbourhood preventive and curative services including those of GP, dentist, pharmacist, nurse, midwife and health visitor. These services were to be based in Primary Health Centres. Groups of Primary Health Centres would be based upon a 'Secondary Health Centre dealing with cases of difficulty requiring special treatment staffed by consultants and specialists or by GPs acting in a consulting capacity'.⁶ Although Dawson's language and culture clearly differ from today's care and environment, nevertheless the emphasis on the healthcare community, the healthcare economy and the patient landscape are features of both Dawson and Darzi despite the intervening years.

In his interview Lord Darzi identifies the *challenge of technology and fragmentation* and goes on to identify three articles of faith. These are:

- 1 the multi-disciplinary approach
- 2 the holistic approach
- 3 the integrated approach.

These deserve further scrutiny.

Lord Darzi links the 'silo' effect to *the complexity that health care has created* following from the inculcation of techniques and identity through professional training

– one outcome of developing highly specialised skills. But as Lord Darzi observes *we build silos between me and you*; but the patients *don't really understand some of these fragmented silos*. So do we need a clearer understanding of occupational differences and boundaries, so that occupational identity can be retained while accepting contributions of others? Lord Darzi identifies the *strengths of primary care ... (with) ... the multi-disciplinary approach to care*. We take this to mean working together without surrendering the techniques and ethics of professional education and training. It involves the recognition that there are (quite legitimately) other 'silos and boxes'. Another response is an inter-disciplinary approach which we take to be working together, retaining the ethics of a profession, but surrendering some technical skills (e.g. the nurse endoscopy role identified by Lord Darzi in the interview). But it should be recognised that until inter-professional education and training is seen as the accepted method of inducting new practitioners then the silos of professional defence are likely to persist.

Lord Darzi suggests that the best primary care provision... is this holistic approach to care and that it is the significant part of the purpose of primary care provision. But is the holistic approach a chimera given the occupational divisions we have just noted? This is surely not the case if this approach is taken to mean that a professional person should treat the lay person with dignity and respect by using 'soft skills' and 'emotional intelligence'. There should be no conflict between empathy, psychological support and professional practice (e.g. breaking bad news), if at the same time the professional is following an evidence-based approach which has been scientifically guided by research, clinical trials, and replication. But the holistic approach should not be an excuse to deny the necessary division of labour that has grown up as a consequence of the fine distinctions developed through science and research for the benefit of patients.

Lord Darzi reports on clear feedback from patients ... (that)... the care we are receiving is fragmented; we want more integration. From this it follows that the principle is to achieve integrated patient centred care. Like the 'holistic approach', an 'integrated approach' to patient care should be relatively easy to adopt. Its ideal form would involve unimpeded access to primary care as first step and, where 'secondary care' is necessary, a visible and supported pathway for speedy and easy access to that care, using the evidence-base to design the best pathway. This implies a parity of status between primary and secondary care practitioners, and management systems that produce as far as possible a seamless web of care and cure with management systems, financial arrangements and geography being no obstructions to such care. For this to occur, what patients want, and, more importantly, need, is better communications rather than any loss of professional

identities. The polyclinics are Lord Darzi's way of describing integrated service provision; and for those who have expressed reservations about the single building approach he points out a federated model may be best in an area where groups wish to work together but have separate practices.

How much resistance will there be to changes advocated by Lord Darzi? The persistence of identified problems, and the consistency of recommendations across the years, illustrates the barriers to change. For example, the early advocacy of the 'polyclinic' by the Dawson Report of 1920 was given a good press and was well-received by the BMA.⁸ However the political climate of the time was not propitious⁸ and Dawson's guiding principle that 'the best means of maintaining health and curing diseases should be made available to all' would for the moment be consigned to the 'world of medical utopias'.⁹ Will the same fault befall the Darzi Report of 2007 or will Lord Darzi's labours inform policy and improve practice? He does lay claim to a distinctive approach, suggesting that other London reviews were *not bottom-up clinically led evidence-based reports*.

Certainly the analysis in the Report is sound and clearly based upon published evidence and face to face consultations. So are his recommendations economically feasible, managerially viable, and professionally, publicly and politically acceptable? Economic viability will require the resources of money, capital, ideas, motivation, and clinical leadership to coalesce around the remedies proposed. Managerial and administrative staff will want to know whether and how structural change will impact on their careers. Such reforms require the recruitment and retention of appropriate administrative and managerial staff to bring to bear efficiency criteria using the dedicated additional resources referred to above. Finally, can stakeholder trust in change be maintained during the transition period? The support of clinicians, the public and the politicians for such change is vital. For clinicians the question will be the impact of such change upon the effectiveness of their clinical practice. For patients and the public at large, their concern will be the perceived outcomes for easy access to high quality services. For politicians, the question will be whether a cross-party consensus on the need for an efficient and effective NHS will make 'party' political debates less important than the possibility of achieving a degree of change which will provide the opportunity to raise the overall standard of primary care in London. This could remedy the deficiencies outlined above to bring the speediest, highest quality, most economically efficient, publicly acceptable health care to all Londoners.

One cannot doubt Lord Darzi's vigour, his rigour in presenting his ideas, and his commitment to patient care and medical science. He has provided a 'nettle to be grasped,' and the Report should stand as one of the

more significant in the somewhat crowded history of deliberations on the future of health care in London.

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