New life or green poultice?

New life for health: the commission on the NHS
Will Hutton, chair
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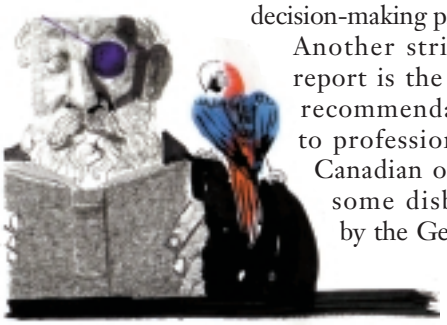
In March 1999, in response to declining public confidence in and rising pressures on Britain's National Health Service (NHS), the Association of Community Health Councils for England and Wales established an independent commission to consider issues of public interest and accountability in the NHS. This commission was chaired by Will Hutton, who was previously the editor of *The Observer*. Hutton's best-selling books, *The State We Are In*, *The State to Come*, *The Stakeholder Society* and, most recently, *On the Edge* (co-edited with Tony Giddons) are widely perceived to be the backbone of New Labour thinking in the UK. The commission report reads with many parallels to the Canadian story, although it is much closer to the traditions associated with the mother of all parliaments.

The report airs a fresh set of ideas for the future of the NHS in Britain: a kind of direct democracy meets the NHS. In a fashion eerily reminiscent of Canada, British newspapers are currently full of stories about health care underfunding and patients on waiting lists for a range of procedures. However, while there are many superficial parallels, there are big differences between the problems of the NHS and those that plague the Canadian health care system. By almost any measure, the UK spends about one-third less than Canada on health care, indeed less than that of most countries in the OECD. The UK nevertheless provides a broader range of coverage than Canada.

Britain's private tier is often pointed to by those in Canada who claim that real market choice doesn't spell the abandonment of the public system. But it's fair to say that private health care in the UK can have a viable economic life only if the public system remains in a shabby state and is generally regarded as second class. There is much talk about strengthening the public tier in the report, but the inherent market requirement for the private tier to perform better draws almost no comment. The report highlights the fall from grace of internal market ideas and the inequities created by contracting with fundholding and non-fundholding GPs, but it does so without directly addressing issues of equity and quality in the public and private financing mechanism.

What is focused on is the need to democratize the NHS, in parallel with the Council of Europe's call for greater citizen participation in health care. An essential recommendation is to give the NHS a constitution to protect its founding principles and guide government policies and practice. Under such a constitution, the NHS would become a public corporation at arm's length from government, with its own board and operational freedom. This is a bold recommendation worthy of consideration in Canada, but perhaps is equally likely to fail miserably on the principal of no taxation without representation.


Fred Sebastian

The commission makes a number of sensible recommendations to ensure that the NHS be made more accountable at the regional and local level by transforming health authorities into elected bodies with a balance of appointments for the sake of expertise. Many of the recommendations are meant to introduce transparency and public right of access to all meetings, minutes and policy papers of executive and advisory bodies within the NHS.

In many respects, what is new about the recommendations is a retreat from the traditions of parliamentary paternalism in favour of a more democratic and transparent approach toward the governance of the NHS. What is striking in this worthy wish for democratic engagement is the absence of any critical reflection on how effective democratic models are elsewhere for institutional and regional governance. In Canada, for example, work by Jonathan Lomas and colleagues has shown that what the public wants with respect to regional authorities (which exist everywhere in Canada except Ontario) is not simply democratic representation but, rather, a balance of expert and clinical inputs and the inclusion of citizens' perceptions and perspectives in the decision-making process.

Another striking aspect of the report is the conservatism of its recommendations with respect to professional self-regulation. Canadian observers noted with some disbelief the granting by the General Medical Council (GMC) in the UK of an unrestricted license to obstetrician Dr. Richard Neale and his subsequent erasure from the registry when several complainants stepped forward. The GMC was aware that Dr. Neale had lost his license in Canada. In the wake of a range of negligent and intentional patient deaths, including the horrific patient poisonings in the case of Dr. Harold Shipman, the British public has been up in arms about how much confidence should be granted to

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the GMC. The Commission on the NHS simply suggests there should be more lay representation on regulatory bodies. This is already the case in a number of jurisdictions in North America and hardly constitutes a bold step forward in professional self-regulation. Hutton applauds the newly established Commission on Health Improvement, the National Institute for Clinical Excellence and adherence to the Patient's Charter as partial answers to the accountability problems in the NHS.

The commission applauds the commitment of the Blair government to improve the base of financial support for the NHS. The British government recently trumpeted a major cash infusion to bring the NHS within reach of the European average in health care spending — promising more than 6% annual growth in real terms over the next four years. While this will go a long way toward relieving some of the current pressures on the UK's health care system, it will fall far short of achieving the objective of meeting the European average in health care spending: this would require roughly a one point increase in overall GDP spending on health care.

An area of glibness in the report is the extent to which it actually wrestles with the difficult issues of trading off "local autonomy and democratic determination" with central policy commitments to equity and public financing. The central role of the NHS is to provide a high-quality base of equitable services for the entire population. This may be difficult to reconcile with a private tier that can exist only by being better than the tier to which all citizens have access as a right. This central–local tension becomes more acute when local authorities choose to restrict access in some specific areas because of local preference, or when they give secondary priority to the aged for a range of life-saving acute care services such as cardiovascular surgery. In other words, how the central government specifies the policy base for what is covered and what is excluded is not easily reconciled with the interpretation of priorities by local authorities on the basis of democratic preference. The commission provides little deliberative reflection on this thorny issue of devolution (which has some parallels pending for Canadians). Saskatchewan's local health authorities are fully elected, an approach that brings its own challenges when concentrated interests seek representation through elected bodies. Alberta has fully appointed boards, well sprinkled with patronage candidates. Lessons may well be drawn from Canada's experience with regionalization and democratization but these will have to await some effective cross-jurisdictional evaluation.

The generous assessment of the Commission on the NHS is that it doesn't try to be more than it is: a progressive reform recipe to democratize the institutional governance mechanisms for Beveridge's great legacy, the NHS.

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One thousand words

Gerald P. B. Murison / National Archives of Canada / PA-136885

Seasickness experiment, Royal Canadian Navy Medical Research Unit, November 1943

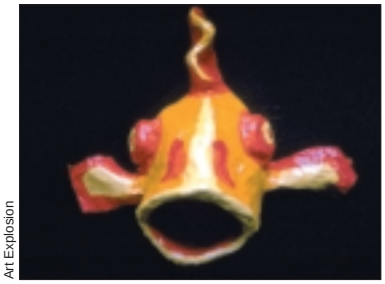
Room for a view

The salmon

There was a spasm, a prolonged quiver, and the salmon lay still on the grassy intervale beside the river. A tall figure in chestwaders bent over the great fish and removed the small hook from the side of its mouth. Earlier in the afternoon he had seen it jump in the rapids below, a shower of glistening droplets, silver in the sun. He knew the salmon would rest in the pool; methodically, he began assembling his rod, attaching the leaders, choosing the fly. At the top of the pool he waded in a short distance and started to strip out line, in short casts at first, the dry fly swinging in small arcs with the current. Gradually the casts became great sweeping parabolas, the fly deftly touching down, catching the current, moving over the next grid of water he wanted to fish. Patiently he worked the water, shifting his position, repeating the process, changing his fly: muddler, brown dorf, hen island special, crimson renown. From deer hair, partridge wing, pheasant feather, multicoloured thread, silver wire he had meticulously tied these flies. They were old patterns his father had taught him and variations he had designed from years of experience.

He rested the water and then, in the early evening, began again. The third fly was a goat-hair butterfly. Halfway through his casting cycle it reached the end of its swing and straightened out beside a rock. The fish rose. There was a swirl; the leader tightened and the reel sang as the line spun out. The salmon ran the length of the pool, jumped, danced on its tail, dove, stayed deep, catapulted to the surface, jumped again. As the battle continued, the angler allowed the fish to run, keeping the line tight, the tip of the rod up, reeling in when the fish rested. When the fish charged toward the shore he reeled in fast, then raised the rod tip as the fish ran to the far end of the pool and down into the rapids. The angler scrambled along the rocky fringe, splashed into the pool past the pine tree arching out from the bank, lost his balance on the slippery rocks in the shallows, kept the rod up and regained his feet. Slowly he manoeuvred the fish back up into the pool. There were more runs, brief dashes, and then the fish stopped resisting the reel. It came in close, then turned on its side; for a moment, their eyes met. The salmon straightened, gathered its strength and headed for the centre of the pool. The angler turned it gently, tipping his rod to the salmon, reeling the fish into the grasp of his large, calloused hand. He looked down at the salmon, transfixed. In the gathering darkness he saw the end of a life, his own impending death. Slowly he headed to his truck and poured himself a tumbler of rum.

I didn't know Archibald MacSorley; he had been a retired partner's patient. One weekend his wife called. "Archie's been on a bender and I've moved in with my sister. For two days he hasn't answered the phone. Would you go over to the house and see if he's all right?" Before going on the house call I pulled MacSorley's chart. It was slim, with only one entry on the problem list: alcohol abuse. The MacSorleys lived in a neighbourhood of bungalows built for enlisted men returning home from the war. The curtains were drawn and the mailbox was overflowing. I rang the doorbell and waited. No answer. I knocked on the door several times and was turning to go when I heard someone fumbling with the lock. I turned; there stood a gaunt figure in a flannel shirt. His gray hair fell forward, framing his lined face as he looked down on me.



Art Explosion

"Who are you?"

"I'm the doctor. Mrs. MacSorley wanted me to drop by."

He stood there, unshaven, his gray eyes averted, studying his hand on the doorknob. Then he ushered me into the tiny, dark, front room and motioned for me to sit in a large comfortable chair with a lace doily on the headrest. He sat on a wooden chair by the door. There was an awkward silence.

"Been eating regularly?" I offered.

"Appetite's not so good."

"When was your last drink?"

"Just before you came."

"Any way I can help?"

MacSorley looked at the ceiling. After a while he said, "No, it's got to run its course."

I asked him if he wouldn't mind showing me how much grub he had on hand. He took me to the little kitchen at the back of the house. It was spotless. There was an empty glass and a half-empty bottle of Captain Morgan on the table. The fridge was well stocked and he had plenty of canned goods.

"Sometimes a shot of vitamin B_1 helps in these situations," I said.

"If you think it will help," he replied.

I checked him over before giving the injection and told him I would like to see him in the office on Monday. He looked me over and gave a faint smile and a noncommittal nod. On my way out I noticed just off the kitchen a large desk neatly compartmentalized with fly-tying equipment.

MacSorley did not come to the office on Monday. A short time later the nurse found out that his wife had moved back home.

Two years later Mrs. MacSorley had a stroke. Her recovery in hospital was gradual, and by the time she returned home she could compensate for most of her residual left-sided weakness. During this time I got to know the MacSorleys. Helen was stoical, observing the world sternly through a very active left eye and a large immobile prosthetic right eye, a legacy of the Halifax explosion. On rare occasions she would let her guard down, revealing a youthful mirth. Archie, as I came to know him, had been born in the city, the second son of James MacSorley, a veteran of the First World War who had been gassed by his own inept Allied commanders. James, with his failing lungs, struggled to support his family as a night watchman. Seasonally he would

escape with his family to the ancestral farm, where he taught his boys to hunt and shared the secrets of his passion for fishing. When he died in 1925 the boys helped support their mother. Archie took night courses in bookkeeping. The MacSorleys were well versed in marginal survival and thrived during the lean years of the Depression. Then in 1939 Archie, too, served his country overseas. He returned home six years later with an unseen scar, a wound that was never mentioned. He began to drink heavily. When he was 40 he married Helen. They had no children, and the pattern of their married life began: bouts of drinking, uneasy truces. Helen ordered her life with an endless round of small tasks. Archie precariously clung to his job and escaped to the woods when he could.

As Helen continued her recovery Archie cooked and looked after the garden and the house. He shopped for her, then with her, took her to appointments, never drank. During this time I fished with Archie and watched his mastery. One day in the office Archie told me about his battle with the salmon, his glimpse of death. I asked him if he was afraid. He didn't answer.

A short time later Helen phoned to say she had moved in with her sister. Archie was on another bender. I phoned their home. There was no answer. The next day there was a message from the hospital that Archie had been admitted the previous night. He had hit a telephone pole with his truck, crushing his sternum and collapsing a lung.

I went to see him. The nurse had just given him an injection and he was resting with his eyes closed. His face had not been injured in the accident, and in the shaded light he looked peaceful. His weathered skin with its furrows and fine lines was the map of an unknown country. I leaned over his ear and asked him what had happened. He pulled at the oxygen nasal prongs, opened his eyes, glanced anxiously at me and clutched for my hand.

"Doc, I saw the fish."

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Occurrences

It worked for me

When I graduated from medical school over 50 years ago I went to work with an older, well-respected doctor in rural Manitoba. Among the things I observed was his treatment of "neuralgia." Neuralgia was characterized by tingling, numbness and paresthesia in the extremities with no demonstrable cause. He treated this condition with an intramuscular shot of vitamin B complex repeated two or three times at intervals of two days and was usually rewarded by the patient's recovery.

When I went on to a practice of my own I continued this treatment, except that, because the intramuscular shots were so painful, I gave the vitamins intravenously, slowly over a period of about 15 seconds. None of my patients ever had a reaction, except that most could taste the vitamins.

I found this treatment remarkably successful with hundreds of patients. In the few cases in which it failed I would go on to further investigation. Usually, three treatments did the trick, and whether it was a placebo effect or not I was not enough of a scientist to subject my patients to double-blind studies, knowing that half my patients would be receiving no treatment. Most GPs have enough trouble getting positive results with drugs that they know are recommended.

I had never been taught about this treatment in medical school, but after moving to a city practice I was comforted to hear a visiting lecturer describe this treatment of "neuritis." He spoke of the anatomy of the peripheral nerve, the central axon covered with insulating myelin, the myelin covered with a sheath of perineurium (or neurilemma). When the myelin insulation swelled for whatever cause, there was no give to the perineurium, and pressure was exerted on the axon, thus producing sensory variations. This swelling could be reduced by injection of vitamin B complex (oral intake never achieved high enough levels to be effective): the pressure would be relieved and the symptoms would disappear.

I worked with a group of doctors and noticed that none of them used this treatment, although it worked for me. However, it appeared that I was overdiagnosing polyneuritis, for one day as I went past the nurse's station I noticed nine syringes of vitamin B lined up on her desk.

"Who else is using vitamin B now," I asked?

"Those are just for *your* afternoon patients," she replied.

Then it struck me: I was a quack! It was not this realization that prompted me to retire soon after, but it was a contributing factor.

I still got calls requesting "shots" for some time after my retirement, usually because of a recurrence of mild paresthesia, but occasionally just because the patient had felt better generally while receiving them.

In any case I was unable to refer my friends to a doctor who would give these injections, because I didn't know any.

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