BMJ 2015;350:h2345 doi: 10.1136/bmj.h2345 (Published 6 May 2015)

VIEWS & REVIEWS

IF I RULED THE NHS

Don't mention the P word

Stephen Gillam *general practitioner, Luton*

If I ran the NHS I would begin by abandoning all "pathways." Many of medicine's woes are self inflicted. Technological advances have driven a degree of subspecialisation that is insupportable. Patients often attest to the bewildering fragmentation of their care. The sticking plaster, often designed to remedy this after the event, is the care pathway.

One patient recently explained to me how her elderly mother's discharge was delayed not for lack of facilities at home but because four different people needed to be involved in signing off her "discharge pathway." Of course, some necessarily complex care requires intricate detailing, but the proliferation of overlapping roles is a driver of inefficiency.

My next bonfire would consume all referral protocols. Many outpatient departments can nowadays be accessed only using their own particular multi-page pro forma. A mole from a nearby transient ischaemic attack clinic reports that, notwithstanding the pro forma, only a third of cases referred to her bear any more resemblance to a transient ischaemic attack than her Saturday morning hangover. Nevertheless, each referral is then legitimised with a carotid Doppler scan, cranial magnetic resonance imaging, and other investigations costing over £1000.

A relatively recent development egregiously combines these perils. Gone are the days when you referred to a single expert. Now we are faced with a panoply of new rapid access or community based clinics. These too come with their own individual referral pro formas with no space for anything other than mostly trivial box ticking. (The first question on the form for the "rapid access palpitations clinic" I have just completed humorously asks whether the patient has palpitations.)

These clinics have often been established on the basis of whim rather than any evidence of efficiency. Appeals for activity data, evaluation, or audit generally fall on deaf ears. Even our clinical commissioning group seems to have little interest in robust evaluation, assuming in the traditional but erroneous way that "community based" equals cheaper and more patient friendly.

If the gap in effectiveness between research evidence and guideline is often great, the gap between guideline and practical pathway is greater. I'm not really against all pathways, protocols, or even community clinics as a matter of course, but they are a legitimate focus for health services research. These are only the symptoms of a deeper malaise. Medical students are trained to manage chronic disease to a high level. Yet the generalist skills needed to manage today's multimorbidity are swiftly eroded, whether in general practice or hospital medicine. This is what I would really seek to reverse, for we have colluded in evolving health services that are unfit for purpose.

I should like to finish on a positive note by offering to pilot my marvellous new invention: the single narrative referral letter with no boxes to tick. No, the SNRL doesn't come with eight pages of guidance on how to write one. There's even a paragraph for some personal detail—but does anyone read that nowadays?

Competing interests: None declared.

Provenance and peer review: Not commissioned; not externally peer reviewed.

Cite this as: *BMJ* 2015;350:h2345

© BMJ Publishing Group Ltd 2015

sjg67@medschl.cam.ac.uk

For personal use only: See rights and reprints http://www.bmj.com/permissions Subscribe: http://www.bmj.com/subscribe