Life & Times
The inverse power law

ONE MAN IN HIS TIME PLAYS MANY PARTS

October's *BJGP* theme is the young and the old. Much like general practice itself then. Three of Shakespeare's *Seven Ages of Man*[1] make up the bulk of medical practice. For inpatient costs the figures for older care are even more marked — while the annual mean secondary care spend for a 50 year old is just over £300, this rises to £2000 by the age of 90.[2] And we are well aware of the social determinants of health, influencing which of these young and old will need most care.[3]

So given that we all sign up to motherhood, apple pie, and patient-centred medicine, presumably parents, older children, and older people themselves have the greatest input into NHS health policy? Especially those on low incomes? But no, most health service policy is dictated by politicians who are middle aged, at least comfortably off, usually reasonably healthy, and not disabled. These policies are then commissioned and overseen by managers of the same ilk.

Yet it is these middle-aged, healthy politicians and managers who wish to reconceptualise medicine as a series of tasks to be performed by anonymous technicians who have the competencies for their bit of the job. A transactional model of medicine instead of a relational model of medicine.[4]

For those who are fit and healthy a transactional model of medicine, delivered rapidly and conveniently by anonymous technicians, may fit the bill nicely. Until they get ill. Or frail. Or need someone whose judgement they can trust for their kids. Then they, like all of us in the end, will need someone they know, that they can trust, whose knowledge of them as a patient is not dependent on a computer file generated by the last dozen minor transactions.

David Misselbrook.

SANS EYES

We talk much about the inverse care law.[5] I suggest that we also need to recognise an 'inverse power law'. Those most in need of health care generally have the least say in how that care is provided. If this is the case then it could weaken much of our own narrative about patient-centred care, and most of our understanding about how to meet patients' real needs via a commissioning process.

Commissioning tends to be driven only by 'objective facts' — that is, aggregate numbers. The numbers game belongs to biomedicine and is usually blind to the lived experiences and needs of those who are ill and thus often vulnerable. We only have to look at the perennial issue, once again in the news, of the gap between health care and social care to see this.

As we look to catching up on what COVID-19 has pushed aside, let alone looking to the future and the inevitable restructuring that is to come, let us seek to reverse the inverse power law. It is easy to say that if we believe in patient-centred health care then now is the time to build it. But can we do this?

AND THEN THE JUSTICE

We must start by listening to the voices of our patients. But we also need to listen to the voices of researchers. Yes, we need numbers, but to turn numbers into medicine, or at least the sort of medicine we would want for ourselves and our families, we need to add in patients' values and lived experience. We need both quantitative and qualitative research. Well, you're in the right journal! As ever, in the research section we have papers that tell us not just how to be better biomedical technicians, but actually tell us how to improve our patients' care.

And, as ever, *Life and Times* gives us food for thought as we reflect on the lived experience of both doctors and patients, the two partners in a dance that can be demanding for both.

Perhaps, like a triumphant Roman general, all politicians, commissioners, and managers should have a patient repeatedly whispering into their ear; *'Remember Caesar, thou art mortal.'*

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