All is not lost genetically

James Le Fanu[1] writes sagely. Many geneticists have fundamentally misunderstood the nature of human chronic disease. They have been successful in finding the basis of clinical systems that are 'broken' with a faulty (state of) constituents, like muscular dystrophy, cystic fibrosis, haemoglobinopathies – here knowing the DNA language of their monogenic origin is important. However, for complex disorders I am reminded of the words of Richard Phillips Feynman (US educator and Nobel Physics prize winning physicist 1918–1988): 'You can know the name of a bird in all the languages of the world, but when you're finished, you'll know absolutely nothing whatever about the bird … So let's look at the bird and see what it's doing – that's what counts. I learned very early the difference between knowing the name of something and knowing something.'[2] How things work matters. Chronic medical disorders are those systems that are either 'out of balance' (i.e. with a faulty interaction of their constituents, e.g. diabetes, migraine, pyrexia, pain, etc.) or 'out of control' (i.e. with a faulty control of the interaction of their constituents, e.g. infection, Stevens-Johnson syndrome, lupus, septic shock, cancer, schizophrenia, etc.). While the lexicon of their DNA-based blueprint is necessary, it is not sufficient for their full clinical revelation. However, this is not an irreducible problem. Funding needs to be redirected to understanding the context in which genes interact (and their interplay with the environment) in determining such medical conditions. The missing heritability can be found!

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Competing interests
None declared

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2 "What is Science?" New York, NY: National Science Teachers Association; 1966

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Continuity – our Achilles' heel

Your editorial, examining healthcare's Achilles' heels, failed to identify discontinuity of care.[1] The article describes a 'healthcare team' but where are those teams that used to manage emergencies? Now it is easier to pass the patient than take the over-arching responsibility for those admitted when we are holding that emergency baton. Healthcare has become a relay race. The least expensive junior doctor emergency rotas usually have the participants out of sync with the senior members of the team to which they have nominally been seconded. Continuity of learning has been superseded by clockwatching.[2]

While a minority of emergency admissions require the expertise of a specific specialty, most patients have multiple co-morbidities and are best cared for throughout their hospital stay by the 'generalist' and his/her team who were holding the baton on the day of admission.

We might look to the universities and Royal Colleges to sort out this mess but that thread of continuity has been passed on to the GMC which has no track record in anything other than disciplinary matters. Alternatively, our politicians could intervene and legislate to put continuity of care at the heart of healthcare and then mould the infrastructure around it. But politicians and their parties are as ephemeral as the succession of management executives imposed upon us and whose only concern is the minimization of their loss-making emergency services.

The inherent risk in healthcare is so patently obvious but no-one appears to be able to see the wood for the trees. An onlooker might see us like a group enjoying a communal bath with the patients the bars of soap. Under the muddied water no one is quite sure who is holding what. When the bathwater has drained away we appear surprised that all the soap has gone down the plughole!

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Reference

1 Donaldson LJ, Lemer C, Noble DJ, Greaves F, Fletcher M. Finding the Achilles' heel in healthcare. *J R Soc Med* 2010;**103**:40–1
2 Aitken M. Do the British value continuity of care? *J R Soc Med* 2009;**102**:1–2

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Continuity – our Achilles' heel

The CMO and his co-authors rightly deplore the lack of meaningful progress in reducing healthcare error.[1] However, the answer may be close at hand. In their informative editorial, they describe 'Toyota's LEAN methodology' as 'increasingly popular in identifying inefficiency and improving performance'. It is difficult to see what benefit might accrue to healthcare in this country from following the principles of a company that is at the centre of a worldwide product safety recall of literally millions of its motor vehicles, and whose profits have plummeted through the floor in the past year. Perhaps it would now be appropriate to call time on our reliance upon inappropriate business models when looking to improve healthcare performance in both the NHS and private sectors.

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None declared

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Author fee: not a great idea

I cannot but disagree with the view that more and more authors would want to publish their research in open-access journals which may charge a fee from the authors.[1] This statement is a loose generalization and many researchers/authors, especially those from the developing world, would not prefer such a journal. The main reason is because such authors do not receive any financial support from their institutions for publication of research. Often the