

comment

“Many still long for an era when matrons were feared” **DAVID OLIVER**

“Suicides rise in line with DWP disability reassessments” **HELEN SALISBURY**

PLUS Ringing time on the “end of treatment” bell; keeping radiology local

THE BOTTOM LINE Partha Kar

Let’s not make excuses for prejudice

It’s not the overt comments that really hurt. At least things are out in the open—in your face, even. They may be unpleasant, but you can choose to stand up to them or walk away. What’s worse is the seeping undercurrent, festering beneath the surface. It’s never in your face, but it’s always there.

I’m talking, of course, about racism. It’s well and truly alive in our society, the NHS, and the medical profession, lurking around a corner with a smirk, a nudge, or a nod.

I’ve worked in the NHS for more than two decades, and attitudes to race have changed in that time, though perhaps only marginally. What used to be overt is now more polished, but it’s still there. Twenty years ago, when applying for a specialist training job in Wessex, I was told, “People of your type are better suited to applying in Birmingham.” Last year, when pushing a clinical commissioning group to improve patient access to technology as part of my national role in diabetes, an executive suggested to me that “maybe you don’t understand our culture.”

As doctors and healthcare professionals, do we experience racism from patients too? Yes, but we have a responsibility to care for and look after patients, and we can draw the line when they’re abusive. But what should we do in the face of racism from fellow professionals? We can look on with a wry smile as, with clockwork efficiency, the cycle repeats: the NHS churns out yet another document on equality, makes yet another pledge on diversity, and then shakes its head when yet another dataset demonstrates the lack of any headway.

The latest phenomenon is even more irksome—the acceptance of racism by people arguing for the need for “free speech.” We need to acknowledge that the defence of free speech has been co-opted by bigots, homophobes, and misogynists.

Free speech is the ability to criticise wrongdoing, or people in power, without fear of reprisal. It’s not the

freedom to say we hate gay people or that brown people make us uneasy. That isn’t free speech: it’s an inability to accept modern society moving to a fairer world.

Here’s a clear statement from someone who isn’t white: I don’t want to have a debate on whether my skin colour makes others uneasy. That categorically sucks.

So, what can be done? I suspect some people will never change. But perhaps it’s worth restating that arguments for free speech are too often used to excuse prejudice. Many of us aren’t keen on having another debate to prove our worth to the system. So, please stand by us, and stop the acceptance of prejudice: as a society, we must be better than that.

My parents used to work here, and they always carried the ambition of becoming consultants in the UK. Whenever something controversial has come up they’ve asked me to be “careful,” because “in the end, you don’t belong”—a view perhaps prejudiced by their experiences in the early 1970s.

Nearly 50 years later, I’d like the NHS to prove them wrong for me: I like to think that I do belong. Don’t I?

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We need to acknowledge the defence of free speech has been co-opted by bigots, homophobes, and misogynists



It's time to call time on the "end of treatment" bell

For patients with recurrent cancer or still undergoing treatment, the sound can be upsetting and demoralising, says **Jo Taylor**

I was first diagnosed with breast cancer in February 2007 and since then I've had many rounds of chemotherapy. I now attend a chemotherapy unit every three weeks. The treatment I'm having is given intravenously through my portacath (a permanent indwelling intravenous line).

Last week, a patient's relative thought that I was a "newbie" after someone helped me with my spilt cup of tea. I was tethered, as usual, to the IV but was being lazy by not unplugging the monitor and stretching to reach the paper towel, so she kindly helped. Normally I whizz around with ease, and after five years of training with the monitor I use it like a partner in a waltz. I overheard another patient say, "She's on her 87th treatment!" with her relative repeating "87th?"

Yes, it's unusual, and over such a long time, but increasingly people have long term treatments for secondary breast cancer and some outlive the 2-3 year median life expectancy. I'm on my fifth "cancerversary" of secondary breast cancer.

It was my first time on this unit when three people had just finished their treatment.

I remembered how good it felt to finish my six chemos, 12 years ago. I remember thanking the nurses, bringing them in some treats and a card to say thank you, and saying: "I don't want to ever see you again (in a nice way), ha ha," to them. And then, there it was, the end of treatment bell.

Pot of gold

It seems a modern phenomenon that everything has to be celebrated loudly and brashly. These bells, generally like a school bell, can be hand held or mounted on the wall, usually with a rainbow to signify that the patient is now at the end and has the pot of gold—health, recovery, and being "cancer free." It's either bought by the hospital ward using donations or by patients themselves.

For those of us living with recurrent cancer who have little prospect of being cured, hearing this bell is like a kick in the teeth.

Many patients who have been newly diagnosed with breast cancer and are undergoing potentially curative treatment have no idea that celebrating in this way is upsetting for fellow patients. Modern science



has helped many of us to live longer, but in the case of breast cancer there is a risk of recurrence. We know that of those early stage primary patients around 30% will develop secondary breast cancer and that risk can be up to 20 years for some types.

Living with recurrent breast cancer is hard. It feels as if the disease has one aim—to kill the person it's growing in. For those who are shouldering this burden it's important we avoid adding to it. I'm sure I'm not the only one who has heard the bell and left the unit in despair, weeping on the way home from treatment which we know will not cure us.

Of course, it's good to celebrate, and I did when I finished treatment for my primary cancer, but they didn't have a bell then. Even if they'd had one I wouldn't have rung it. As a

The joy of local



Radiology these days is a global affair. There are Australian radiologists sitting in central London reporting overnight studies from back home and UK radiologists bravely enduring life in Sydney to provide a similar service to some NHS hospitals.

The benefits to the patient of having their emergency night time scan reported by a wide awake radiologist are obvious, the benefits to the radiologist even more so. There are a few potential disadvantages for the patient—communication between radiologist and clinician is inevitably impaired if they are on different sides of the world, the level of background information available to the radiologist is likely to be reduced, and we are always vulnerable to a computer catastrophe—but on the whole it looks like a good arrangement. What about the radiologist? Is there any downside?

When you ask radiologists what they enjoy

A significant part of the reward I derive from my job has to do with providing a service to my community

about the job, most mention the problem solving aspects—we are a tribe of puzzlers. Many refer to the breadth and variety afforded by a career in radiology, the constant innovation, and, of course, the sheer beauty and fascination of the images themselves. Interventional radiologists point to the immediate rewards of being able to arrest life threatening haemorrhage or prevent the development of a devastating stroke.

For me, I've come to realise that a significant part of the professional reward that I derive from my job has to do with providing a service to my local community. Colleagues who work in an urban environment find it hard to believe that when I sit down to report a batch of radiographs or scans I frequently recognise



friend said, it felt like tempting fate.

People think the bell is encouraging. I disagree, I think it's divisive and cruel.

Fight analogy

Additionally, many people don't like the "fight" analogy. The bell being rung is like the end of a round in a boxing match. But who wants another round? Perhaps I should ring it to count the number of times I've had treatment, but I'd be there for a while and people would get sick of it and want it stopped.

Maybe we should just call time on the bell. There are many other patients like me and it is surely time for chemotherapy and radiotherapy units who use these bells to rethink them.

Jo Taylor is founder, After Breast Cancer Diagnosis

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the names. That's what I would lose if my job was confined to providing services to a remote population. When I read about the growth of online GP services, I think how much more this must apply in primary care. Without getting too sentimental, one of the most pressing needs for doctors is to rediscover the joy of practising medicine and to reconnect with the associated professional rewards.

Unravelling the mysteries contained in a set of medical images is intrinsically fascinating, at least to those of us who do it for a living. But how much more meaningful is it when the images belong to someone who shops at the same supermarket, whose house you might have run or cycled past at the weekend, and whose children might attend the same school as your own? Localism can bring additional rewards. Even for a radiologist.

Giles Maskell is a radiologist in Truro. He is past president of the Royal College of Radiologists

Degrees and the nursing crisis

The NHS's biggest existential threat is its workforce crisis. And, although modern healthcare is a team venture reliant on interdisciplinary working, nursing is the NHS's most numerous, visible, and trusted clinical group. One with a workforce crisis even more pressing than that in medicine.

Against this backdrop, the zombie trope that "overeducated nurses" lead to declining standards of care has made an unwelcome return in parts of the media.

In a 2014 study in nine European countries, every 10% increase in degree educated nurses was associated with a 7% fall in patient mortality. England had one of the lowest percentages of graduate nurses in its bedside workforce. Then we have the immense (and growing) contribution to patient care by advanced nurse practitioners educated to masters level, in services throughout the NHS.

Yet last month saw a series of posts by the journalist Harriet Sergeant, who has criticised nursing degrees for years, claiming that "the rot set in" with the introduction of bachelors degrees as standard; that this somehow worsened care (though with no evidence beyond anecdotes) and that it deterred potential applicants with the right skills. Letters appeared in the *Times* and the *Telegraph* banging the same drum. The lines of argument are ill informed about modern nursing roles, the complexity and acuity of patients, the range of technologies, the pressure on services, and the growth in evidence for practice. Different eras require different approaches.

Behind these arguments lies an unhealthy dose of covert snobbery and sexism

These things don't seem to affect the correspondents' ongoing certainty. What nurses mostly need, they say, are innate values of compassion, caring, and common sense, for what should be a vocation, not a profession: degrees somehow render nurses incapable of compassion and empathy, uninterested in practical, hands-on care, despite graduate nurses throughout the NHS delivering precisely this.

Despite our understanding that improving quality and safety requires flat hierarchies, teamwork, a just culture, and an awareness of human and system factors, many still long for an era when "matrons were feared" and nursing could be reduced to nutrition, pressure sore prevention, and crisp uniforms. We don't see these unevidenced arguments or assumptions made about doctors or other health professionals: behind them lies a dose of covert snobbery and sexism.

Several factors are driving the crisis including the removal of study bursaries; cuts to funding, staffing, and CPD budgets; insufficient availability and funding of student placements; immigration rules, which put off overseas applicants; and workload, falling morale, and burnout.

Whatever the cause of the problems, they won't be solved by less training and education—an argument that should surely have had its day.

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Doctors' duty to patients in a fractured welfare state

Like many other GPs around the country, I'm spending more and more time writing medical reports to appeal on behalf of patients who have been refused welfare benefit payments. Welfare is a right: we have a welfare state we all pay into through taxation, and we rely on it when we are sick or become unable to work. It's a mark of a humane society that we look after each other in this way.

The main grounds for refusing incapacity benefit is that the person has been found fit to work by someone at an outsourced assessment company. Many of my patients with severe physical or mental health difficulties spend weeks in a state of heightened anxiety before an assessment. I know that it takes some patients all of their energy and resolve to get up, dress, and make it to a GP appointment on time. Engaging in the world of paid work is simply not a realistic ambition for them, however much they'd love to. Unfortunately, their struggles may not be captured in the questions the assessment service uses on its form.

At the assessment, patients have to discuss and demonstrate what they can and can't do. This is difficult, unpleasant, and undignified. Most people want to project the best version of themselves—one that's strong and capable, making the most of their abilities. A patient with learning difficulty may say that he can use public transport independently, omitting that he's safe to do this only if he's been taken on the same journey 15 times by his carer. Admitting to a stranger

My patients' safety, dignity, and comfort are being compromised



that you have problems controlling your bladder or bowels is deeply undignified. Some patients, determined not to be beaten by their disabilities, minimise the pain it causes them to walk 50 yards.

A negative ruling by the Work Capability Assessment body is often followed by months of desperation as we appeal the decision. In most cases (65%, says the Department for Work and Pensions) the original decision is overturned on appeal.

This all creates extra work for doctors: not just writing reports but also supporting patients with worsening mental health as a result of this punitive system. Suicides and antidepressant prescriptions have both been shown to rise in line with disability reassessments. Patients judged as no longer qualifying for support seek our help for their desperation and low mood, but cognitive behavioural therapy and antidepressants are a poor answer to a fractured welfare state. We're instructed by the GMC, in its document *Duties of a Doctor*, to "take prompt action if you think that patient safety, dignity or comfort is being compromised."

My patients' safety, dignity, and comfort are indeed being compromised. It seems unlikely that reporting the DWP to the GMC will be productive.

However, as doctors we should use our collective voice to stand up for our patients and demand change to this deeply damaging system.

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LATEST PODCASTS



Planning for the unplannable

How do you plan for high impact events (terrorist attacks, natural disasters, disease outbreaks) that are low in probability but with high potential to wreak havoc? In this podcast Amy Pope, who served as US deputy homeland security adviser to President Obama, talks about how she coped with these events, including the 2014-15 Ebola outbreak. In this extract, she discusses the public reaction to the first Ebola case detected in the US:

"People became quite hysterical. Managing public perception was more critical in many ways than the actual outbreak because the fear was driving people to do silly things and politicians to make very silly decisions. We had governors in the south who would not allow trucks with Ebola waste to transit through their state even though the waste had been sanitised and there was no possible way there was any Ebola virus on it. You had crazy reactions that were driven by fear, politics, and sometimes people looking to score political points."

Doctors under attack in Syria

As Syria enters its ninth year of conflict, doctors are struggling to provide healthcare while facing an unprecedented number of targeted attacks. In this podcast *The BMJ's* Elisabeth Mahase speaks to human rights lawyer Len Rubenstein, who chairs the Safeguarding Health in Conflict Coalition. He highlights the scale of attacks on healthcare sites and the toll on staff:

"We recorded more than 250 attacks in Syria in 2018 and there really is no historic precedent we're aware of where hospitals have been so thoroughly and apparently deliberately targeted as in Syria. This has resulted in incredible deaths, incredible suffering, and of course denial of healthcare to people. These health professionals are doing remarkable work under terrible conditions."

Listen to this podcast to hear from doctors what it is like to work in Syria.



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Edited by Kelly Brendel, deputy digital content editor, *The BMJ*

Safety of candour: how protected are apologies in open disclosure?



Doctors need more certainty about whether and how they can safely apologise to patients, warn **Gilberto Leung and Gerard Porter**

Doctors are often unsure about whether apologising to patients will leave them open to legal consequences.¹

Among the many implications of the Hadiza Bawa-Garba case, the idea that even a doctor’s written reflections in their portfolio could later be used against them in court has raised concerns in the medical community.² This uncertainty could affect doctors’ willingness to disclose mistakes and to give patients the apologies they deserve.

The situation is complicated by the statutory duties of candour in England and Wales³ and in Scotland,⁴ that now require health services and practitioners to give a factual explanation and to apologise after a notifiable incident. Although it is widely thought that existing apology laws in Great Britain would confer sufficient protection,^{5 6} a closer look indicates that the situation is far from straightforward. This paper examines some of the legal issues of apologies and their implications for healthcare.

Protecting apologies to benefit patients

Saying sorry for a medical error, whether legally required or not, is a doctor’s ethical and professional duty. A proper apology can show respect and empathy to patients and their families, lessen emotional

Examples of apology protection

Country	Scope of protection	Examples in practice
United States	Subject matter	State laws may protect apologies related to accident only, healthcare only, or both
	Evidential admissibility	Some states (eg, Arizona) protect an acknowledgment of fault for “unanticipated outcome” in healthcare; some (eg, Delaware) expressly exclude it from protection; some (eg, Iowa) are silent on the matter
Canada	Evidential admissibility	Most—but not all—provinces and territories protect “words or actions” that “admit or imply an admission of fault” in connection with “any matter.” An apology cannot be admitted as evidence in court to determine fault or liability, nor does it affect insurance coverage
Australia	Evidential admissibility	Admissions of fault are protected in some states (eg, New South Wales, Queensland) but not others (eg, Northern Territory, Victoria)
Hong Kong	Applicable proceeding	Judicial, arbitral, administrative, disciplinary, and regulatory proceedings
	Evidential admissibility	Protection for an expression of regret, sympathy or benevolence, admission of fault and liability, and statement of fact. An apology does not void or affect any insurance cover

A proper apology can show respect and empathy to patients and their families

distress, and promote a strong sense of partnership in the patient journey. It may also reduce legal action that can add financial and psychological burdens to patients; studies have shown that most patients want and expect an apology after things have gone wrong.¹ Conversely, failure to apologise or an evasive “partial” apology could increase psychological distress and exacerbate dispute. Unfortunately, patients’ experiences with apology and disclosure continue to fall short of their expectations.⁷ The importance of encouraging proper apologies through the availability of clear and appropriate legal protection cannot be over-emphasised.

Apology protection in law

There are more than 50 apology laws around the world that aim to

encourage apologies by preventing them from being an admission of fault and liability.⁸ When not legally protected, an apology statement can lead to legal or disciplinary proceedings against the apologising doctor, with serious consequences for their career and registration. The scope of protection varies, depending on the definition of apology, the applicable subject matter and proceeding, and the evidential admissibility of apology statements according to statutes (table).⁸

Evidential admissibility is a particularly important issue: a medical apology can contain different types of statement, some of which might point towards the standard of care and be used as evidence in court to establish liability, even if the apology statements do not by themselves amount to a direct admission of fault and liability. From a legal perspective, it comes down to how a particular apology provision in a legal statute is worded and applied. For a narrowly drafted or narrowly construed apology provision, for example, an expression of sorrow (eg, “I am sorry that the complication happened”) might be legally protected, but an admission of fault or a statement of fact (eg, “I made a mistake and tied off the wrong

KEY MESSAGES

- Apology statements in open disclosure could amount to an admission of fault and liability, be used in court as evidence, and affect professional indemnity coverage
- Apology statutes aim to encourage apologies by protecting those who make them in this regard, but the degree of protection varies between countries
- In Great Britain, protection does not seem sufficiently clear or comprehensive, offering doctors little assurance as to the legal consequences of the apologies which are now mandated by statutory duties of candour
- The law should be clarified to facilitate open disclosure for the benefit of patients, their carers, and healthcare professionals

artery”) might still be used as evidence in court.⁸ The sheer existence of an apology statute does not guarantee that all medical apologies will be protected to the same extent.⁹ Against this backdrop, we further explore the apology laws in Great Britain.

England and Wales

The Compensation Act 2006 in England and Wales contains a single provision aimed at preventing an apology from amounting to “an admission of negligence or breach of statutory duty” (box 1). But unlike statutes in many other countries, there is no mention of whether and how apology statements can be used as evidence in court. An explanatory note in the act states that “the provision is intended to reflect the existing law,” which is not helpful, as English courts have previously either denied¹⁰ or accepted¹¹ an admission of fault in apologies as establishing liability.⁹

The 2006 act does not give a definition of apology. It is defined under the separate duty of candour statute as “an expression of sorrow or regret” that is treated as distinct from other elements in a notification (box 1).³ When read in conjunction with the “of itself” part of the 2006 act provision, there is no reason to think that any statement other than one that expresses sorrow or regret would be legally protected.

The 2006 act has not been invoked in legal actions concerning medical apologies and open disclosure, but the inherent uncertainties cannot be disregarded. Notably, the Medical Protection Society recommends to its members that an appropriate apology should take the form of “I am sorry this happened to you” as opposed to “I am sorry I caused this to happen to you and it is my fault.”¹² Whether this advice is commensurate with the duty of candour, and deemed satisfactory by patients, is subject to debate.

But as the 2006 act does not apply to disciplinary or criminal proceedings, one can reasonably argue that an apology admitting fault could put the doctor in an unfavourable position. A doctor whose error had caused patient death, for example, might find that their fault admitting apology is admitted as evidence for a

charge of medical manslaughter. The irony is that these are precisely the circumstances that require and deserve a full apology.

Furthermore, an admission of fault or liability by the doctor could potentially void professional indemnity coverage. Apology statutes in some other countries contain specific provisions to prevent this, but the Compensation Act 2006 does not. Thus, despite the existence of an apology statute, doctors in England and Wales cannot have full confidence about the available level of legal protection in terms of evidential admissibility or any assurance concerning the other implications of an apology.⁹

Scotland

In Scotland apology is defined under the duty of candour statute as a “statement of sorrow or regret” that “does not of itself amount to an admission of negligence or a breach of a statutory duty.” There is no provision on evidential admissibility.⁴ The use of apologies as evidence in general is disallowed under the Apologies (Scotland) Act 2016 but this does not apply to apologies made under the duty of candour—the reason given for this exception is to avoid “any overlap” between the two statutes. This is unsatisfactory as it remains unclear whether apology statements are admissible as evidence or not (box 2).¹³ As in England and Wales, apology protection in Scotland does not extend



An admission of fault or liability by the doctor could potentially void professional indemnity coverage

Box 1 | Apology protection and the statutory duty of candour in England and Wales

Section 2 of the Compensation Act 2006 provides that: an apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty.

Under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which governs the duty of candour, a notification to the affected parties must: (a) be given in person by one or more representatives of the health service body; (b) provide an account, which to the best of the health service body’s knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification; (c) advise the relevant person what further enquiries into the incident the health service body believes are appropriate; (d) include an apology; and (e) be recorded in a written record which is kept securely by the health service body. (s. 20(3))

to disciplinary hearing or criminal proceedings; the effect of an apology on professional indemnity coverage is similarly unclear.

Protecting mandated apologies

The lack of sufficient and clear apology protection can deter doctors from tendering “full” apologies, or indeed any apology, which is ultimately detrimental to patient welfare. That apologies are mandated under the duty of candour statutes also puts the responsible person in a difficult position, as non-compliance is a punishable offence in England and Wales and reportable in Scotland.¹⁴

More worrisome is the general lack of awareness about the limitations of existing apology protection. The legal requirement under the duty of candour is that a doctor’s notification to the affected parties must also be in writing. A (mistaken) assumption could be made that simply because an apology statute exists, all apology statements contained in a notification will be legally protected. But, as mentioned, the scope of apology protection is not necessarily comprehensive, and courts in other common law jurisdictions have redacted and protected some apology statements while leaving others, such as those pointing to the standard of care, admissible in evidence.¹⁵ Although such legal precedents from overseas are not binding in Great Britain, they might still be given considerable weight.

As such, a compliant healthcare professional could have tendered a full apology, both orally and in writing,



MALCOLM WILLET

Box 2 | Apology protection and the duty of candour in Scotland

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, which governs the duty of candour procedure, defines apology as a “statement of sorrow or regret in respect of the unintended or unexpected incident” (s. 23(1)) and provides that “an apology or other step taken in accordance with the duty of candour procedure under section 22 does not of itself amount to an admission of negligence or a breach of a statutory duty” (s. 23(2)).

The Apologies (Scotland) Act 2016 provides that an apology “is not admissible as evidence of anything relevant to the determination of liability in connection with that matter” and “cannot be used in any other way to the prejudice of the person by or on behalf of whom the apology was made” (s. 1).

The Apologies (Scotland) Act 2016 Act “does not apply to an apology made in accordance with the duty of candour procedure” (s. 2(2)).

An explanatory note states that “the inclusion of this exception avoids any overlap between this procedure and the act in terms of how apologies made in the context of the duty of candour procedure are treated.” Does it mean that an apology made under the duty of candour is inadmissible because the two statutes are supposed to direct the same treatment of apologies, or that it is admissible because it is not covered by the Apologies (Scotland) Act 2016?

without realising the potential legal risks that it might incur.

Presently, guidance simply re-states the existing apology provision without additional explanation.^{16 17} Many stakeholders are probably unaware their apologies are potentially admissible evidence; that an apology could void professional indemnity coverage; and that existing protection does not apply to criminal and disciplinary proceedings.

There is little doubt that professional education and training on the nuances of apologising should be enhanced, but the lack of legal certainty renders it difficult, if not inappropriate, to make any strong recommendations on how doctors should apologise and disclose error. Good communication skills and a sincere and empathetic approach towards disclosure continue to be the best approach to redressing harm to patients and reducing legal action.

One further consideration is that, even if an apology was given “full protection” legally, the doctor who apologised might still be sued for negligence. The apology, however, would not form part of the evidence used to prove negligence.

What is of utmost importance and urgency is to clarify or improve the laws. The least that legislators in England and Wales can and should do is provide a working definition of apology in the Compensation Act. We also need clearer guidance on evidential admissibility and the effect of apologies on professional indemnity coverage in England and Wales.

Whether the scope of protection should be expanded is a more complex and contentious issue. Some experts have said that apology laws should be drafted in more expansive terms where disclosure and apology are integrated.¹⁸ The Victorian government in Australia, in the wake of introducing mandatory open disclosure, sought such amendments to its apology law.¹⁹ Others have argued that a healthy degree of judicial discretion is necessary in deciding whether to admit apology statements of high probative value lest apology protection interferes with a claimant’s rights to justice.⁹

In this regard, the recently enacted Hong Kong Apology Ordinance has been criticised for prohibiting evidential admission of factual statement in apologies.²⁰ There is no ready solution, but a conceivable compromise is to avail but limit more expansive protection to apologies by amending the duty of candour statutes while preserving the original provision and intent of the apology laws.

Yet, a substantial change in apology protection is unlikely in Great Britain soon. The two duty of candour statutes are still young. In its post-legislative assessment of the Compensation Act, the Ministry of Justice found no reason for changing the apology provision.²¹ During implementation of the Apologies (Scotland) Act, the proposal to protect statement of fact in apologies had to be withdrawn after strong political opposition.²² The continuous engagement of professional peers in informed discourses and a concerted effort at lobbying will be

A substantial change in apology protection is unlikely in Great Britain in the near future

critical to bring about the necessary improvement.

Conclusion

The prevailing notion that apology laws in Great Britain provide sufficient protection to complement the statutory duties of candour is not well supported. We affirm a previous concern that the inclusion of a requirement for apologies under the statutory duty of candour can be problematic.²³ The lack of sufficiently clear apology protection can potentially put compliant apology makers at risk and hamper the implementation of the statutory duties of candour.

This is not to say that stakeholders should refrain from making apologies; rather, they should harness the positive effect of apologies and adopt an empathetic approach towards open disclosure. We should also pursue parallel initiatives that encourage institutions to proactively offer compensation to patients in deserving cases. This is likely to bring coherence to the process and reduce litigation.

The law is supposed to protect patients’ rights, and their right to proper apologies warrants our full and appropriate attention. We need greater clarity in the way the apology laws in Great Britain are interpreted and applied. Legislative steps to bring more certainty to the scope of apology protection, though challenging and contentious, will facilitate the safer use of mandated apologies to the ultimate benefit of patients and their carers.

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LETTER OF THE WEEK

Put GPs first by investing in general practice

Iacobucci paints a bleak picture of working in general practice, particularly in deprived areas (Seven Days in Medicine, 18 May). But his assessment is supported by research and reports over several years. We know the GP workforce faces major challenges, but we disagree that these are insurmountable—urgent action is required.

Creating health promoting general practices would strongly support the government's pledges on prevention, public health, and reducing inequalities. The health promoting general practice is essentially the gold standard for health promotion.

To become a health promoting general practice, staff must commit to creating a healthy working environment, integrating health promotion into activities, and establishing alliances with other relevant groups.

Creating a healthy workplace might improve the working life of GPs, attract more graduates into general practice, and keep hardworking, experienced GPs in the profession for longer.

Funding in general practice is lower than current needs. To meet existing health challenges, government commitment and investment are urgently required. As part of this, a national health promoting general practice award should be designed with incremental progression. The award should be facilitated and supported by public health specialists from local authorities.

For most general practices, achieving gold will not be easy, nor will it be resource neutral, but it will be in the best interests of GPs and other staff, the NHS as a whole, and—most importantly—patients.

Michael Craig Watson, trustee, John Lloyd, honorary vice president, Institute of Health Promotion and Education

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SEX WORKERS' HEALTH

A “managed approach” to sex work

In 2014 a “managed approach” model was introduced in a designated area of Leeds to meet specific challenges of street based sex work, in partnership with third sector organisations (Public Health, 6 April).

Specific operational rules in designated hours enable a strategic approach to managing enforcement around soliciting or kerb crawling. Police enforce laws relating to indecency, crime, and antisocial behaviour.

In 2017, Leeds Sexual Health had 373 contacts with 166 sex workers, 57% of whom had never accessed the service before. Interactions between street

Interactions between street working women and support services increased by 110%

working women and support services increased by 110%. Reporting crime to the police rose from 7% in 2013 to 52% in 2015 (maintained in 2018), indicating that less fear of arrest encourages women to report.

By driving sex work underground, we make sex workers invisible. Our experience confirms that decriminalisation of sex work is the safest option to enable sex workers to access health and support services.

Madeleine A Crow, community sexual and reproductive health specialist trainee year 3; Jane Brauholtz-Speight, outreach nurse, Leeds Sexual Health; Emily Turner, outreach and support worker, Gemma Scire, chief executive officer, Basis Yorkshire; Colin Dickinson, communications officer, Leeds City Council; Anna Hartley, consultant in genitourinary medicine, Leeds Sexual Health

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RESILIENCE TRAINING

Help us be resourceful

The R word is becoming prevalent in discussions of the NHS workforce and needs to be banned (Personal View, 18 May). It seems to have spilled over from industry and management and is now seen as an absolute prerequisite for working in the NHS.

In terms of medical students being taught resilience, as they progress through SATS, GCSEs, AS levels, university clinical aptitude tests, biomedical admissions tests, medical school interviews, and then A levels, any unresilient people would have fallen by the wayside.

Doctors shouldn't need to be increasingly resilient; what they need to be—and are—is resourceful. Resourcefulness is the ability to find quick and clever ways to overcome difficulties, to be good at problem solving,

to adapt well to new and difficult situations, and to think creatively.

No more resilience training—help us to be more resourceful.

Rod S Jennings, GP, Bedworth

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A slap in the face

Can we shift the discussion away from resilience? I appreciate why Ripullone and Womersley want to investigate didactic possibilities, but continued use of resilience as a management buzzword does not reflect the experiences of our junior clinicians at the frontline.

We work in a system with resource and staffing shortages and high levels of burnout. Poor morale seems to have created a downward spiral, with many junior doctors choosing to take time out of training, producing further rota gaps.

Resilience training is a slap in the face to hard working professionals as it shifts the onus to improve on to them, implying that if they can't cope they mustn't be resilient enough and need to put on a brave face.

G R Huntington, foundation doctor year 2, Dartford

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NEW POLITICS AND THE NANNY STATE

Big tobacco and the Italian Senate

Big tobacco companies using political links to foster their business is concerning (Investigation, 18 May). In Italy, a “sunshine act” proposal to make financial links between healthcare professionals and industry more transparent has been approved by the Chamber of Deputies and is currently being discussed by the Senate.

In the meantime, the Senate has hosted a conference on cardiovascular prevention, with the non-conditional support of Philip Morris, discussing the potential benefits of heated tobacco products. Invited experts expressed their interest and support for these products, which can reduce health risks and might help smokers to shift from cigarettes.

Risk reduction strategies should be proposed when adequate evidence is available, which is not yet the case for heated tobacco products. This is especially

important when such topics are brought to the attention of politicians to avoid the risks of undue lobbying.

Giulio Formoso, pharmacist, Roberto D’Amico, professor of medical statistics, Reggio Emilia; Maria Grazia Celani, neurologist, Teresa Cantisani, neurologist, Perugia; Silvia Minozzi, epidemiologist, Rome; Michela Cinquini, statistician, Paola Mosconi researcher, Vanna Pistotti, librarian, Milan

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Ditch the abuse and use caring state or informative state instead

The BMJ examines the Institute of Economic Affairs’ “bullish libertarianism” and denigration of the nanny state (Investigation, 18 May). “Nanny state” as a term of abuse should be actively countered.

Two elements of the nanny state are relevant—public health interventions and public education on health matters. The first should be re-defined as the “caring state,” the second as the “informative state.”

Information is needed to

counter the advertising and marketing of “exploitative business.” The tobacco industry has spent far more on advertising and promotion than any state funded antismoking campaign.

The “caring state” is needed to ensure that food standards are maintained and to counter the use of nutritionally unsound ingredients, such as fructose syrup, added to prepared and processed foods by “greedy business.”

I worked for the nanny state for many years. It was and still is called the NHS.

Adam Moliver, psychiatrist, Cheltenham

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Financial transparency: necessary but not sufficient

Right wing think tanks are beholden to their funders and repay their patronage with “free market” advocacy (Editor’s Choice, 18 May). That such advocacy is often at odds with



public health is unsurprising, given its usual opposition to environmental protection and the regulation of commodity industries.

The BMJ sensibly advocates full disclosure of think tank funding as a prerequisite for participation in public debate. But this is unlikely to be enough for two reasons. First, such disclosures are frequently misleading and use euphemistic language. Second, disclosure of financial interests is not enough to mitigate bias and may even aggravate it. One New Zealand think tank proudly declares corporate funding alongside its enthusiastic free market agenda. Transparency around conflicts of interest is inadequate to protect public health in a market driven economy.

David B Menkes, academic psychiatrist, Hamilton

[Cite this as: *BMJ* 2019;365:l4149](#)

SENDING PATIENTS HOME

We need capacity to assess patients properly

Every clinician who deals with patients at the frontline understands the stress associated with discharge decisions (David Oliver, 18 May).

We do a snapshot assessment: predicting the trajectory of illness is often impossible. At least for some patients, problems are due to premature discharge. We are conscious of the 25-35 patients lined up on trolleys or sitting in chairs for hours or even days waiting for a bed. So, we send the “walking wounded” home. Management mantras such as “discharge to assess” encourage us to take risks.

Are we managing the patients or the bed crisis? We need capacity in appropriate places to assess patients properly. When

an adverse event happens after discharge, appropriate frontline clinicians should perform a balanced assessment of the discharge process. Currently, neither the patients nor the systems we work in would look favourably towards the clinician who discharged the patient. Vedamurthy Adhiyaman, geriatrician, Rhyll

[Cite this as: *BMJ* 2019;365:l4229](#)

Data must lead decisions

Oliver is not alone in losing sleep over discharging patients. I trained in the 1990s, and at no time in my career has there been training available on how to manage patients with multiple morbidities and on many drugs. This lack is due to lack of knowledge—these patients didn’t exist 20 years ago or even 10. We are all winging it, and bed pressures inevitably influence

decision making. Most of the time, experience gives the right answer, but we need to cut ourselves (and each other) some slack when we occasionally get it wrong.

Early discharge has risks, but so does delayed discharge—the difference is that you can’t identify a decision maker for the latter.

Having ready data on how many right decisions we make and what we think is an acceptable error rate would be helpful. Maybe the royal colleges should take the lead?

Gillian M MacDougall, ENT consultant, NHS Lothian, Edinburgh

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Loaded with expectation

Discharge is loaded with the expectation that any later untoward event will be blamed on the discharging doctor. This is despite knowing that the therapeutic content of admissions

and emergency department attendances is often quite thin. In the presence of doubt, patients are admitted or continue in hospital, which causes blocked beds and packed emergency departments. “As long as I don’t discharge, I can’t be blamed” is the mantra. Tests are ordered just to delay discharge.

Patients might need to be more reasonable about events after discharge. We also need safety nets and to communicate how things might go.

We should stop using the discharge decision as a cause of morbidity: it creates anxiety, guilt, and risk averse behaviour, which bedevils healthcare. The consequences of not discharging are rarely attached to anyone.

Graeme M Mackenzie, hospital GP, freelance, Twickenham

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Sue Povey

Molecular geneticist who masterminded human gene naming

Susan Margaret Povey (b 1942; q University College London 1967; MD, FMedSci), died from ovarian cancer on 11 January 2019

Publication of the complete sequence of the human genome in 2003 was a landmark event, and Sue Povey, Haldane professor of human genetics, played a key part in its success. She led the team at University College London that was part of the Human Genome Project, and successfully took on the hugely complex task of organising gene nomenclature.

Early years

Povey grew up in Leeds. After a stellar academic career at Notre Dame Collegiate School, she studied natural sciences and genetics at Girton College, Cambridge, and then medicine at University College London (UCL) in 1964. She was interested in the genetics of susceptibility to leprosy and one summer travelled overland to a leprosy hospital in India.

After qualifying Povey practised medicine for two years in Liverpool and Huddersfield before taking a diploma in tropical medicine and working in Algeria for the charity Save the Children. It was here that she decided her calling did not lie in clinical medicine. She was excited by genetics and when the head of the UCL genetics unit, Harry Harris, said she would always be welcome as a researcher, she took up his offer.

Professor of genetics

In 1970 Povey began her career at UCL, where she stayed until she retired in 2007. She became deputy director of UCL's biochemical genetics unit in 1989 and was appointed Haldane professor of human genetics in 2000. She also became editor of *Annals of Human Genetics* and was coauthor of more than 60 gene mapping papers.

Povey was fascinated by human gene mapping, attending the annual Human Gene Mapping Workshops between 1975 and 1991. Each chromosome had a committee, and at different times she chaired those of chromosomes 1, 2, and 9.

In the first year the workshop met, attendees summarised a handful of genes and produced handwritten tables—but the

Povey was interested in the ethical problems of sharing data in genetic testing



PHILIP AND NICOLA POVEY

vast increase in quantity and complexity of gene data quickly necessitated an online database and stringent naming policy. In 1996 Povey took over from Phyllis McAlpine as chair of the International Human Genome Organisation gene nomenclature committee.

Whereas McAlpine had worked on her own, Povey secured funding for a team of skilled curators and programmers to keep up with the outpouring of data. She was a skilled manager, and under her leadership more than 20 000 genes were named, and the committee's names and symbols became the prime identifiers in the main human gene databases. Povey appreciated that standard nomenclature could be controversial, sometimes quoting a contemporary, Michael Ashburner, who said that "biologists would rather share their toothbrush than their gene name."

Genetic disorders

Early in her career, Povey investigated the development of hydatidiform moles and ovarian teratomas. As gene mapping progressed in the 1980s, work started to look for genes associated with individual diseases. In 1985 Povey was asked to investigate a faulty gene for tuberous sclerosis complex. Her work linked the gene TSC1 to the ABO blood group. She had a talent for collaboration and worked with eight other laboratories on a paper identifying the gene on chromosome 9.

A second gene (TSC2) was discovered in 1997, and Povey set up the TSC variation database, a vital tool for clinicians and researchers. Their work led to treatments such as rapamycin, which is also used to coat coronary stents, prevent organ transplantation rejection, and to treat lymphangioleiomyomatosis.

Povey knew personally the effects of rare genetic disorders. In 1974 when researching the genetic background to deficiency of α -1-antitrypsin, she diagnosed it in her own niece, Katheryn, who died at the age of 13.

Ethics and retirement

Povey was interested in the ethical problems of sharing data in genetic testing, and after retiring from UCL in 2007, she chaired a working group to produce guidelines for specific genetic variation databases, as well as continuing to curate the TSC mutation databases.

When Povey's mother died, her father came to live with her, and they set up home in Cheddington in Buckinghamshire, which they shared with her much loved dogs. Povey liked to walk at weekends and had some memorable walking holidays. She had scoliosis, which latterly limited her activities. She leaves her brother, Philip, and nephew, Ian.

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Bill Jenkins

Epidemiologist and activist who blew the whistle on the US government's Tuskegee syphilis study

William Carter Jenkins (b 1945; graduated BA mathematics, Morehouse College, 1967; MS biostatistics, Georgetown University, 1974; PhD epidemiology, University of North Carolina, 1983), died from complications of sarcoidosis on 17 February 2019

William ("Bill") Carter graduated from the historically black Morehouse College, in Atlanta, Georgia, with a bachelors degree in mathematics, and, in the 1960s, was one of the first African-Americans recruited to the National Center for Health Statistics, a branch of the public health service.

He received a doctorate in epidemiology from the University of North Carolina in 1983 and did postdoctoral work in biostatistics at Harvard University School of Public Health. Also in 1983 he married fellow epidemiologist Diane Rowley, who said that her husband had been an activist since school when he registered people to vote. At college, in the 1960s, he was a foot soldier in the Student Nonviolent Coordinating Committee and was imprisoned for demonstrating against a white only restaurant. Later, Jenkins helped found an underground publication, *The Drum*, dealing with problems of racism and inequality at work. He is best known for blowing the whistle on the Tuskegee syphilis study, while still a government employee.

Soaring rate of syphilis

Jenkins had started a promising career at the US Public Health Service in the mid-1960s when he first learnt of the Tuskegee syphilis study. In the study—which started in 1932 and was conducted by the public health service in collaboration with the Tuskegee Institute in response to the soaring rate of syphilis—600 poor, black Alabama sharecroppers, 399 of whom had syphilis, became participants in research, in exchange for free healthcare, food, and burial insurance. The scientists wanted to observe what untreated syphilis would do to the human body.

Originally the study was projected to last six months, recalled Jenkins, but in 1936, it was decided to follow the men until their deaths, without informing them. The men

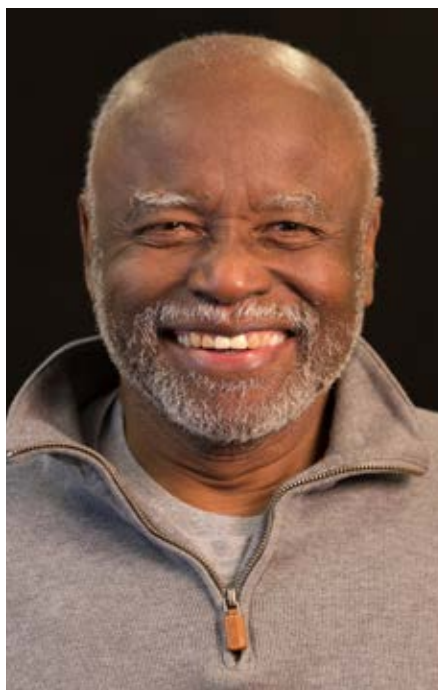


PHOTO COURTESY OF THE AMERICAN FRIENDS SERVICE COMMITTEE

Jenkins devoted his career to tackling racism and injustice in healthcare and working for the Centers for Disease Control and Prevention at the beginning of the AIDS crisis

were told that their "bad blood" was causing their illness. For four decades these men were studied and deceived into believing that they were being treated, when they were not, and were allowed to pass syphilis to their wives and children—even when penicillin became available in 1947.

Several men had terrible symptoms of unchecked syphilis—blindness, brain damage, paralysis, and death. This study was still ongoing when Jenkins joined the Public Health Service in 1967, and it first came to his attention a year later. He learnt it had been widely covered in medical journals, so it was not secret.

He blew the whistle on its poor practice and worked with fellow epidemiologist Peter Buxtun to get it stopped, but their first efforts were rebuffed. The study finally came to an end in 1972, after Buxtun contacted the Associated Press, and the story was published on the front page of the *New York Times*: "Syphilis

victims in US study went untreated for 40 years"—which sent shock waves across the nation. The study was soon halted by a congressional hearing.

A subsequent lawsuit brought financial compensation to the study's survivors, and years later Jenkins led the campaign to get an official apology from President Bill Clinton to the victims of the study and their families in 1997. The Tuskegee syphilis study is now widely acknowledged to be one of the darkest chapters in the history of medical research in the US.

Tackling racism and injustice in healthcare

For 10 years Jenkins oversaw the government's participants' health programme, which gave free lifetime healthcare to victims of the Tuskegee study and eligible family members. The last man, Ernest Hendon, died in 2004. As part of the apology the government paid for the National Center for Bioethics in Research and Health Care at Tuskegee University. The study's ethical shortcomings resulted in changes to federal law to require greater patient protection, including informed consent regarding patient participation in medical studies.

The Tuskegee study changed Jenkins's life, and he devoted the rest of his career to tackling racism and injustice in healthcare and working for the Centers for Disease Control and Prevention (CDC) at the beginning of the AIDS crisis. At the CDC, he was one of the first researchers to recognise the disproportionate rate of AIDS in black men, and he worked to reduce rates of the illness, later becoming the CDC's director of AIDS prevention for minorities.

To help prevent further injustice he worked to recruit more minority students, particularly African Americans, into public health careers, creating programmes at CDC and developing the master of public health programme at Morehouse School of Medicine in the mid-1980s.

Jenkins was active in professional organisations and was much honoured. He leaves his wife, Diane Rowley, and their daughter.

Rebecca Wallersteiner, London

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